CHRISTIAN MEDICAL JOURNAL OF INDIA

CMJI

Communicating Health
Since 1895

A Quarterly Journal of the
Christian Medical Association of India

VOLUME 27 I NUMBER 3

JULY - SEPTEMBER 2012

The Call to Jonah

Dr Mathew Cherian

What ails healthcare today in India? How can we transform today's values in Indian healthcare centres, many of which are like the Nineveh of yore?

Transformation at Makunda

Dr Vijay Anand Ismavel

A hospital that had shut down is now thriving and that too by focusing only on the poor. A transformed hospital that is transforming lives...

For the Least of These

Rev Nicole Ashwood

The Caribbean reportedly has the highest collective reports of gender-based violence. Two centres offer hope to these battered women, thus transforming their lives.

transforming lives

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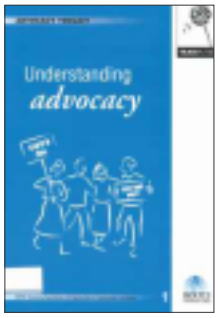
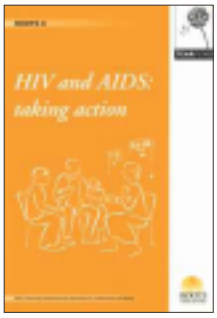
PILLARS and ROOTS are a series of books published by Tearfund, a Christian relief and development agency working with a global network of local churches to help eradicate poverty. The publications are aimed to develop a capacity and knowledge of individuals, organisations and churches. They provide practical information that can help to bring about positive change





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In the last issue of CMJI, the name of Joseph Eye Hospital was erroneously carried as Nelson Eye Hospital. We regret the error.

LETTERS TO THE EDITOR

Respected Sir,

I have received the Biennial Conference issue of the CMJI (26.4 & 27.1). Thank you very much. I enjoy reading the material but my vision is so poor that I can't read easily or fully. Keep very few big words.

I am very old. I became a Life Member of CMAI during Alice Zachariah's time. I retired from the College of Nursing, AFMC, in 1980. I was the first Principal who started the BSc Nursing College in 1964. I was on deputation to the College of Nursing, Delhi, and worked at the CON, AFMC, at Pune from 1964 to 1980.

I was able to do what I could because of the mercy and grace of God. My Lord and Saviour Jesus Christ's grace has led my life till my very old age – nearing 90. I haven't enough words to thank Him and praise His great grace to me. The CMJI is a good publication and has good articles. I thank CMAI, all its members and the Nurses League for sending me the good journal. The only sad part is that I can't read and get inspired.

[Mrs Aleykutty Mani
Retd. Principal, CON, AFMC,
MIG No. 7, Fort Nagar, Fort Cochin
Kerala]

I went through the articles of the CMJI issue on Quality in Mission Hospitals. Yes, quality is a mandate. The achievements of Bangalore Baptist hospital motivate other member institutions to get quality accreditation. I would like to congratulate Dr Alex Thomas and his team. "Quality of Care in Small and Medium-Sized Mission Hospitals" by Mrs Mercy John and Dr John C Oommen shows the reality of quality care in mission hospitals. Dr Vijay Aruldas' interview with Dr Sukesh C Nair specified facts about CMAI's role in accreditation. Ms Neetu Kumari Singh's article was very informative.

I believe that the articles regarding quality accreditation in the healing ministry revitalise and motivate our member institutions to get accreditation and maintain quality health care in the name of Jesus Christ.

[Prof M Thanga Darwin
Sree Mookambika College of Nursing,
Kulasekharam, K K District, Tamilnadu]

LETTERS / ARTICLES FOR CMJI

We invite your views and opinions to make the CMJI interactive and vibrant. As you go through this and each issue of CMJI, we would like to know what comes to your mind. Is it provoking your thoughts? The next two issues are on the subjects "Living in Conflict Zones" and "Brokenness to Healing". Share it with us all. This may help someone else in the network and would definitely guide us in the Editorial team. E-mail your responses to: **jaya.philips@cmai.org**. Articles of humour, cartoons etc. are welcome.

Guidelines for Contributors

SPECIAL ARTICLES

CMAI welcomes original articles on any topic relevant to CMAI membership - no plagiarism please.

- Articles must be not more than 1500 words.
- All articles must preferably be submitted in soft copy format. The soft copy can be sent by e-mail; alternatively it can be sent on a CD by post. Authors may please mention the source of all references: for e.g. in case of journals: Binswanger, Hans and Shaidur Khandker (1995), 'The Impact of Formal Finance on the Rural Economy in India', Journal of Development Studies, 32(2), December. pp 234-62 and in case of Books; Rutherford, Stuart (1997): 'Informal Financial Services in Dhaka's Slums' Jeoffrey Wood and Ifftah Sharif (eds), Who Needs Credit? Poverty and Finance in Bangladesh, Dhaka University Press, Dhaka.
- Articles submitted to the CMAI should not have been simultaneously submitted to any other newspaper, journal or website for publication.
- Every effort is taken to process received articles at the earliest and these may be included in an issue where they are relevant.
- Articles accepted for publication can take up to six to eight months from the date of acceptance to appear in the CMJI. However, every effort is made to ensure early publication.
- The decision of the Editor is final and binding.

LETTERS

- Readers of CMJI are encouraged to send comments and suggestions (300-400 words) on published articles for the 'Letters to the Editor' column. All letters should have the writer's full name and postal address.

GENERAL GUIDELINES

- Authors are requested to provide full details for correspondence: postal and e-mail address and daytime phone numbers.
- Authors are requested to send the article in Microsoft Word format. Authors are encouraged to use UK English spellings.
- Contributors are requested to send articles that are complete in every respect, including references, as this facilitates quicker processing.
- All submissions will be acknowledged immediately on receipt with a reference number. Please quote this number when making enquiries.

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Transforming Lives…

Prof Dr George M Chandy

As I reflected on the theme "Transforming Lives", my thoughts went back to the story in St. Mark's Gospel, Chapter 2 – the story of the transformation of a paralytic. The Gospel writer narrates an incident in the life of Jesus when He visits Capernaum. As soon as He came to 'the house', people gathered and there was no place even to enter through the door. Houses in Palestine opened directly on to the street. The roof was made of wood which could be removed fairly easily. Most houses would have a staircase which would lead to the terrace.

The story is of five friends, one a paralytic, and four others keen to take him to Jesus for healing. As there was no way to enter the house, they planned an ingenious method to help their friend. They carried him up the stairs, opened out the roof, let down the cot and lowered him in front of Jesus. What followed is an amazing narrative, wherein, seeing their faith, Jesus was moved. He pardons the sins of the paralytic and heals him. We read that the patient arose, carried his cot and walked home. As the story unfolds, we see transformation taking place in the life of the paralytic, physically and spiritually. I am sure that the transforming effect would have involved his friends and many who were in the house at that time. This was possible because of a healer (Jesus), the faith of the patient and the supportive effort of his four friends. Transforming lives is a holistic activity, involving individuals, family, friends – in fact, the society as a whole.

This edition of the CMJI seeks to present articles, which give us a better understanding of 'transformation'. Rt Rev Bp Daniel's reflections and Mr C B Samuel's thoughts address questions on transformation from the Biblical perspective. Real life experiences from the lives of Dr Vinod Shah and Dr Mathew Cherian, from the Makunda Christian Hospital under the leadership of Dr Vijay Anand and Dr George Varghese's monumental effort in the Spiti valley are sure to inspire us.

Rev Asir Ebenezer invites us to dream of a new world order, while Mr Selungba Singh's article challenges us to attempt transformation through ministry within and among churches. Rev Nicole Ashwood takes us to the Caribbean and tells us of the moving experiences of the Coles amongst 'the least of these'.

We are introduced to WPC – Whole Person Care – by Dr Latha Mathew of the EHA. Dr Saira Paulose recounts a moving story of a couple that the Shalom team ministered to. Mr Anand Peacock describes how the transformation touches both the giver and the receiver and that it can be a community experience. Dr Stanley Macaden describes how the Word of God had a life-changing effect on one of his patients with advanced liver cancer.

'Lives that Speak Beyond Their Times' features a brilliant, brief biography of Dr C K Job. Ms Ashley Thomas has assessed the work of the CMAI in the light of the WHO Health system framework. The special article on our mission hospitals features the CSI Kalyani Multispeciality Hospital in Chennai.

I hope and pray that these articles will inspire you and give you a transformational experience.

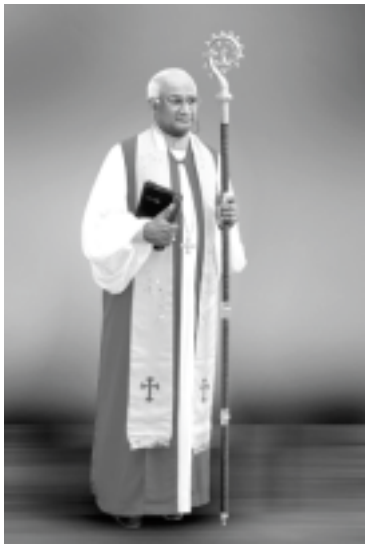
Our congratulations to Dr Alex Thomas and the fantastic Bangalore Baptist Hospital team for the prestigious FICCI Healthcare Excellence Award 2012 for successful innovation in operational excellence.

Prof Dr George M Chandy

Rt Rev Dr K G Daniel

"Be Transformed"

(Romans 12:1-2)



Rt Rev Dr K G Daniel

EXPLORING THE DIFFERENCE BETWEEN BEING "CONFORMED" AND BEING "TRANSFORMED", THE AUTHOR SAYS THAT GOD ACTS WITH MAN'S SPIRIT TO RENEW THE MIND

In the Malayalam language there is a saying – "If you reach a snake-eating country you should eat the central part of the snake". The idea is that you should identify with the situation and be absorbed into it. How far can it be applied to Christian life? The Bible is clear about this. In Romans 12:1-2, Paul makes the following plea regarding transforming our lives:

> **"I beseech you therefore, brethren, by the mercies of God, that you present your bodies a living sacrifice, holy, acceptable to God, [which is] your reasonable service. And do not be conformed to this world, but be transformed by the renewing of your mind, that you may prove what [is] that good and acceptable and perfect will of God."**

Human beings by nature imitate. Actions are based either on the world or on the will of God. Both have the same ending – "form". But the base words are different. One is "con" and the other is "trans". Both are used with the same meaning, based on the changing outward fashion and the inward renewal of mind. The second one is unchanging.

Not to be conformed, according to the will of the world. "Conform" means changing as the changes of the world like a chameleon which changes its colour as per the color of the surroundings. Do not allow the world to change you according to its fashion. When you conform according to something, you lose your identity. It can always go back to its old form. Conformation does not have a goal, except to survive as part of a system. Conformation is a state of no life and strength. We are called to live as free people as per the will of God.

The Greek word for transformation is **metamorphoo** (met-am-or-fo'-o) lit., "**to change into another form**" (Vine's), from which comes the word "metamorphosis". Used to describe a change of form and content (e.g., when a caterpillar becomes a butterfly). In the New Testament, this word is used to describe: What happened to Jesus on the Mount of Transfiguration (**Matthew 17:1-2**). Christians are "**to undergo a complete change, which under the power of God, will find expression in character and conduct**" (Vine's). **It was not that the outer face of**

Transformation is a passive act. We allow Christ's will to change our minds. Man does not have any role to play. The word used for this surrender is sacrifice

Jesus was transformed but the whole body became translucent and changed into a new form. The change from within was transformed to the outside form of Jesus. What is to happen to Christians in their service to God?

Transformation is a passive act. We allow it to happen to us. Allow Christ's will to change our minds, which will result in transformation; the will of God to change the inner part. That is why it is the result of the mercies of God. Man does not have any role to play except to allow God to act. Since God is the Spirit, He acts with man's spirit, which is renewal of the mind. The word used for this surrender is sacrifice. In sacrifice, a living thing is offered to God to be slaughtered.

Both conformation and transformation are processes. One is a process of adjusting to the world without any aim

except to survive. Transformation is also a process where a person is transformed continuously according to the will of God, with the power of the Holy Spirit. Conformation is floating with the current and transformation is swimming against the current. Confirmation is a state of weakness. But transformation is a state of power exercised.

a. TO BECOME LIKE CHRIST...
b. TO LIVE LIKE CHRIST...

This in fact is healing. "Healing is restoring to the purpose for which God has created a person". God's purpose for man's life is His will for him. It will be different from person to person.

As Baultman says, "Healing is the strength to live, suffer and die. It is not the condition of my body, it is the condition of my mind to the varying conditions of my body, where travel hopefully is better than to reach." This really is transformation.

Transformation is an act of stability. But conformation is not. The reason is that it is based on something (the world) which always changes. But God is the same, yesterday today and forever. The greatest problem today is to keep the identity. The struggle is to be IN the world without being OF the world. What is the purpose? The purpose and the goal is to be agents of transformation.

Today the temptation is to conform to the Church without transformation of the inner life. The inner life is expressed by the outer. The result of true worship is living and holy worship, by presenting the body as a living sacrifice. The sacrificial animal should be without blemish; must be a healthy one. To keep a body healthy, it should act according to the purpose for which it is created. That stage is called healing, where healing is restoring to the purpose for which God has created. When the body is used according to God's will it will be holy and acceptable to God. That can happen only with the transformation of the mind. The mind should be tuned to the will of God. This really is worship. This is God's grace in our lives. But it should be expressed in our body and life – that is ethics. So, worship is God's grace and ethics is man's gratitude towards that grace. This gives the purpose of life. It gives answer to the question of why we live.

Transformation is an act of stability. But conformation is not. The reason is that it is based on something (the world) which always changes. But God is the same, yesterday today and forever

Knowing this purpose and adoring the Creator is worship. Worship has two parts. One is negative, which is mortification of the body and its desires. The other is positively presenting the members of the body. We have to offer the different parts of the body as a living sacrifice, not for sin but to God's will. Then our feet walk in His path. Our lips speak the truth and spread the gospel. Our tongue will bring healing. Our hands will lift the fallen. Our ears will listen to the cries of the people….

The gift of discernment is the basis for renewal. It is the work of the Holy Spirit. Both the Spirit and the Word of God renew the minds of the people.

Transformation is non-conformity. Throughout the Bible it is seen thus. Lev. 18:3ff. "Do not follow their practices…. Do not do as they do…." Do not let the world around you squeeze you. As stated earlier, the purpose of conformation is to survive in a world of competition. This is a question of existence. This is influencing the Christian service, world and faith also. So in order to survive we may do unnecessary tests, unwanted operations, unethical practices etc. ■

Rt Rev Dr K G Daniel is Bishop, East Kerala Diocese, Church of South India

FROM OUR ARCHIVES

The Journal of the Christian Medical Association of India,
Burma and Ceylon
Vol.XII. No. 6

Heal the Sick

By Rev F E England, MA, BD, PhD

Every week in the Christian World the Rev F E England, MA, BD, PhD answers questions sent to him by his readers. On two or three occasions the question of spiritual healing came up and in the *Christian World* of July 22 and 29 respectively the following excellent and comprehensive answer was given...

'Then he called his twelve disciples together, and gave them power and authority over all devils, and to cure diseases. And he sent them to preach the Kingdom of God, and to heal the sick'. (Luke ix, 1; compare x, 9).

After Christ's departure some of the disciples, particularly Peter and John, were notably successful in their healing work. We gather, also, from the Epistle by St. James that prayer and anointing were used by the elders of the Church in cases of sickness.

From these facts it is considered that the Church's charter to heal the sick still remains; and a short time ago the Upper House of Convocation in the Church of England gave general approval to a service for Unction and the laying on of hands in connection with the healing of the sick, two Bishops voting against it on the ground, as the Bishop of Birmingham said, that such practices might lend colour to superstitious ideas about the curative value of holy oil and of the laying on of hands.

Transformation Through Empowerment

(Names changed to protect identity)

Dr Mathew Santosh Thomas

Almost 12-13 years ago, the C project entered the tribal-dominated K block of KO district with the aim of improving the health status of the communities. This was the time when men and women were not used to interaction with outsiders and it was especially hard to find women health volunteers. With a series of clinic and house visits over a span of 1½ years, the project was able to generate goodwill among the villagers. After this, a group of 10 women came forward to shoulder the responsibility of the CHV. These women were trained in various health aspects for three years and then they started functioning. This was the time when the project pondered over a strategy and idea to empower women.

After this, the SHG was taken as a tool to empower women with the understanding that empowerment would lead to transformation through improved self image, the realisation of self worth and increased bargaining power. The formation of SHGs was facilitated and the women who were trained as CHVs, being the smartest of the women, got leadership roles in the SHGs. Then a series of capacity building programmes were undertaken and with the help of the banking and the government sector, IGPs (Kosa Silk) got initiated. Slowly, the income levels of the women in the villages started increasing. They got frequent exposure to the market and the government sector. Around 20 groups reached the turnover of over Rs.5,00,000 at one point. In evaluation, the project felt that the groups had attained the performing level and women were empowered enough to take the process of development forward. In order to consolidate the work, groups were federated, the women took over the leadership of the federation and the project took up the role of consultant to the federation.

THE IMPORTANT THING IS NOT TO CONFORM TO THE WORLD BUT TO CLING FIRMLY TO WHAT ONE KNOWS WILL EVENTUALLY TRANSFORM EVERYONE AROUND

After 1½ years, a shortage of cocoons was felt in the market. After organised advocacy by the project and the women, the groups were issued cards on which they could buy cocoons from government cooperatives. Meanwhile, traders were in dire need of cocoons. They asked the women to sell the issued cocoons to them at higher prices. At this point the women had two options – to work and earn, or earn by black marketeering the quota of cocoons issued to them. Most of the groups fell prey to the desire to earn easy money by black marketeering the cocoons. With support from government officials, one project person and traders, these women formed a lot of groups on paper and did everything to earn easy money. There was only one woman leader who stood against all this. She never got into such things. She had influence over three groups and these groups decided to work and earn from cocoon reeling.

All this corruption continued for two years. Then a government enquiry started and the quota system to groups was abolished as they were found to be indulging in wrong practices. The system of open sale to traders started and these traders captured the market by money power. The groups have no work at present. A series of litigation and accusations also began.

All this led the project to think – 'what is real empowerment'? After a lot of discussion, the project team came to the conclusion that real development and empowerment lies within the liberating power of Christ which transforms the individual. This is the difference between empowerment in terms of what the world thinks and a Christian understanding of empowerment. To conclude, it is worth mentioning that the woman who decided not to black market the cocoons was one who held on to values as taught in the Bible. ■

Dr Mathew Santosh Thomas is Executive Director of the Emmanuel Health Association

What Does Transformation Look Like?

Mr C B Samuel

What is transformation after all? Citing references from the Bible, the author draws up a picture of a world that is transformed

In recent years the concept of transformation has become an accepted way of talking about the goal and process of development. It is however a concept that found acceptance mainly because

It would not be wrong to say that transformation is both a process and an end. In the Bible, there are many images of change which form a central part of God's reign

'development' was seen as limited and purely materialistic. In Christian development literature its popular usage was mainly through a Wayne Bragg's paper, "From Development to Transformation" in The Church in Response to Human Need, Vinay Samuel and Chris Sugden, eds. (Regnum, 1987). Bragg suggested a conscious shift to transformation instead of development. And his reason was that,

> "Christian church and para-church agencies seem to have accepted uncritically the basic premises of the Western ideal of development. Tom Sine suggests that these premises are derived more from the secular humanism of the Enlightenment than from Christian thought, and that they are "based on the implicit belief that human society is inevitably progressing toward the attainment of a temporal, materialistic kingdom.... The so-called 'developed' modernised world needs transformation to free itself from a secular, materialistic condition marked by broken relationships, violence, economic subjugation, and devastation of nature." (p 21-22)

and 'transformation' he defined as "… a joint enterprise between God and humanity in history, not just a mechanistic or naturalistic process. It involves a transformation of the human condition, human relationships, and whole societies." (p 21)

But on what constitutes transformation there is no agreement. Unfortunately the word itself is no longer purely used in the social development sector. And this has made transformation mean anything and nothing at all.

The Greek word, "metamorphoo," translated as 'transformation' in the Bible is used four times in the New Testament (Matthew 17:2, Mark 9:2; Romans 12: 2 and 2 Corinthians 3:18) and the word describes the transfiguration of Christ in the gospels

What would a transformed world look like?

as well as the change in believers in becoming more like Christ while on earth. And so it would not be wrong to say that transformation is both a process and an end. Even though the concept of transformation as it is used today is not found either in the Old Testament or the New Testament, there are many images of change which form a central part of God's reign. The prophetic literature is full of teaching on such visions of change and they provide useful themes to help us understand transformation as the process and outcome in a society where God reigns or rules. It is impossible in a brief overview to look at the wide range of images. But even a cursory look at one such passage provides adequate fuel to inspire our imagination.

Zechariah Chapter 8 is what I want to look at to draw a few images of transformation.

When God returns to Zion and dwells in Jerusalem things begin to happen. Zechariah's array of occurrences begins with "...Then Jerusalem will be called the City of Truth, and the mountain of the Lord Almighty will be called the Holy Mountain." (8:3 NIV) **Truth** and **Morality** will be the foundations of such a society. Truth and morality are prime values in God's world. It is unfortunate that today truth has become lost in knowledge and facts. In a country like ours, truth-speaking is usually sacrificed for the value of saving face. It is sad that today it is more important to be politically correct than to be right. To work for transformation would be to work for truthfulness in our society. It is true that despite our contribution to the nation, Christians have hardly influenced her values. Transformation is only possible when we influence values and that implies to be involved in transformation of cultures.

Next in the list is **health** and that is portrayed in the image, "Once again men and women of ripe old age will sit in the streets of Jerusalem, each of them with cane in hand because of their age." (8:4) Health is an indicator of the transforming presence of God's reign. Isaiah notes, "Never again will there be in it an infant who lives but a few days, or an old man who does not live out his years; the one who dies at a hundred will be thought a mere child; the one who fails to reach a hundred will be considered accursed." (65:19-21) And notice that the aged will become visible in the city streets. This is contrary to current practice in many of our cultures where the aged are in the margins of society. Interestingly, another important part of God's world is the **place of children.** Zechariah 8:5 reads, "The city streets will be filled with boys and girls playing there". What a beautiful picture of the city!! Transformed societies are places where children will be children; not abused, sold or even institutionalised. Children in God's kingdom will be important members; "The wolf will live with the lamb", Isaiah notes, "the leopard will lie down with the goat, the calf and the lion and the yearling together; and a little child will lead them." (Isaiah 11:6)

Land and how we deal with it is an important indicator of transformation. Even in a casual reading of the Old Testament one is impressed about the place of land in God's dealing with the people. So the emphasis on land in God's transformed world should not be a surprise. An important part of God's reign is **to restore land back to the people**. Now while it is true that the reference in Zechariah 8:7-8 is about Israel being brought back to their land, such divine intervention was not limited to just Israel (Amos 9:7). This aspect of restoration of people is a very crying need in our time when more than 25 million people are displaced from their land; some as refugees, some internally through conflicts and others displaced through development. Transformed society ensures the protection of people's ownership and stewardship of their land.

Images of prosperity and plenty fill the visions of the prophetic future. Eradication of hunger and poverty and responsible stewardship of the environment are indicators of transformation in a society.

Next on the list of characteristics is **security**. Isaiah portrays that in God's reign, "He will judge between the nations and will settle disputes for many peoples. They will beat their swords into plowshares and their spears into pruning hooks. Nation will not take up sword against nation, nor will they train for war anymore." (Isaiah 2:1) Zechariah writes that there will be safety in the streets again, because God reigns. Similarly, people will get **just wages** – another indicator of transformation. God is concerned about the wages paid to our workers; and James would warn the rich that the wages that they did not pay the workers will cry out to God (James 5: 4). Not only are humans not exploited but even animals will be treated well.

A final significant aspect of God's reign in this rich array of characteristics is the **flourishing of Creation**. Images of prosperity and plenty fill the visions of the prophetic future (Ps 144: 12-15). Eradication of hunger and poverty and responsible stewardship of environment are indicators of transformation in a society.

This list is not exhaustive but a good sample of God's transformation, which is comprehensive and is already present and working in and through those who belong to him. So what does it mean for institutions involved in transformation? First, is to know that transformation calls for a ***comprehensive engagement***. Sector specific interventions while useful cannot bring in total sustainable change. Second, the transformational process should be demonstrated in the **lifestyle and culture** of the institutions that are engaged in change. ***Credibility of transformation is the credibility of the instrument of transformation.*** And finally, transformation requires more of a ***collective engagement***. To be comprehensive we need to be able to include many others in the process; both from the community and even outside. ■

Mr C B Samuel is Minister at Large, Emmanuel Hospital Association and Inspire India

FEATURE

The Call to Jonah
an Answer to the Current Standards of Medical Practice

Dr Mathew Cherian

What ails healthcare today in India? How can we transform today's values in Indian healthcare centres, many of which are like the Nineveh of yore? Good Christian doctors are called – Jonah-like – to preach the transforming and life-giving message there

I have been practising interventional radiology for the past 22 years – state-of-the-art, minimally invasive procedures in the brain and other blood vessels of the body. We perform a wide variety of procedures. All of them are minimally invasive and provide a permanent cure to a significant percentage of patients who end up with us. However, even today, we find that this is used as a last option. This is especially true for procedures like fibroid embolisation. Several of the patients who come to us do not have any symptoms related to fibroids. Most of them were advised to undergo a hysterectomy. Some of these women were around 30 years old. It is hard to believe that there are several doctors practising in India today who wouldn't think twice before removing the uterus and ovaries in an asymptomatic woman convincing her that she has tumors which could lead to cancer. The same holds true with several others who come to us. We see patients with hepatocellular carcinoma who have had explorative laparotomies when the CT clearly showed that the tumors were not resectable; patients with peripheral vascular disease who have come to

Machines do but assist ethical care from medical personnel

us when their legs are ready for amputation and they tell us stories of how a doctor had been seeing them for the past several years and promising them that medicines would sort the problem out.

There is another dangerous problem that has crept into modern medical practice. Often, a patient is told that a tumor has been completely resected. Many of them do not even have a follow-up CT performed to know the truth. I have seen a patient who was supposed to have had a Whipples, where the CT showed a perfectly preserved head of pancreas and duodenum. This patient may have been billed for a Whipples. I could cite a hundred such examples. Brilliant doctors capable of doing some of the technically demanding surgeries use their talent in the most unscrupulous ways.

So the big question is, 'WHY'? As doctors, we are called to be compassionate. We are expected to deliver treatment options which we would dispense to close relatives of ours. Yet, today, a patient enters a modern super-speciality hospital stuffed and overflowing with the latest technology with trepidation and with the fear that many of the investigations ordered may not be necessary and that the expensive treatment options given to them are unwarranted.

To a great extent, I believe that this is because of the lack of good role models in teaching institutions and, further, in places of work. Owing to the lack of role models, a young student starts emulating a teacher who is today considered successful based on the car he drives or the house he lives in. Sometimes it is not a matter of material things. I have seen people carried away by a teacher who has a large number of publications to his credit. Publications are by no way harmful but the obsession to publish sometimes pushes a physician to perform procedures which are either impossible to perform in a certain situation or go beyond the grey zone to increase his statistics.

Owing to the lack of role models, a young student starts emulating a teacher who is today considered successful based on the car he drives or the house he lives in

Both these situations are not fair to the patient. At the same time they can have a powerful impact on a young student whose innocent mind soaks up this trait he sees in the doctor whom he admires and later, ends up practising along the same lines.

So how do we produce more role models? I believe in this verse where Jesus Christ says to the people that it is the sick who need a physician. We have to come to terms with the fact that this country is saturated with sick physicians, their minds distorted by greed for popularity, wealth and fame. If I consider myself an ethical, honest physician, then I have to ensure that I am in this very place to bring about a change, or, at least to be a role model or a benchmark for others to compare themselves to.

Very often, many of us who come from very devout Christian backgrounds are made to feel that the only place we can practice would be in a mission hospital or a "Christian medical centre." Doctors who practice in large corporate hospitals (the so-called five star centres) are made to feel like traitors to the tradition. Thus, most of the large, tertiary-care hospitals in the country do not have even one doctor who can set up a standard for others to follow or be in a position of influence within the system to change the standard of care.

I am reminded of the prophet Jonah, whenever I raise the topic of the need for outstanding doctors who practice medicine with the highest ethical standards. Jonah was a Jew and a very devout one at that, and his one prayer would have been to see the enemy, the Assyrians, destroyed. However, it came as a shock for him when he was asked to go and preach a life-transforming and life-giving message to the Assyrian king. He found this such a controversial task that he preferred to run away from God's Will, lest he looked like a fool in the eyes of his peer group.

I believe many of us with outstanding skills, especially from centres like Christian Medical College, Vellore, are called to take up this challenge of taking up jobs in these very hospitals which look like Nineveh to bring about change.

There are only a few Christian doctors in the institution where I work. Yet, we are able to play an important role in ensuring that the hospital is not involved in giving cuts or kickbacks to referring physicians. We can also be instrumental in showing that ethical standards in patient care will finally lead to a successful practice, even if it takes time. It's easy to share God's love and to demonstrate the integrity that He expects from us in a secular hospital.

In conclusion, I would like you to open your eyes to the vast opportunity that lies around us in the many super-speciality hospitals. The infrastructure provided in these hospitals is as good as seen in the best centres in the world. However, several patients who come here are not from well-to-do families. They are willing to sell everything they possess in the hope that somebody there will bring healing to a loved one and I believe many of them get cheated because we refuse to take up the challenge of being there, bringing about transformation, both by being role models and a source of change. ■

Dr Mathew Cherian is Chief of Radiology services, Kovai Medical Centre Hospital, Coimbatore. He is ex-President and founder member of the Indian Society of Vascular and Interventional Radiology

The Inside Story of What Really Happened

Dr Vinod Shah

A small but brave step taken by a doctor opened the doors for transformation to happen in his own career. As other talented people pitched in, it also set in motion a long-due educational programme. The PGDFM has touched the lives of many GPs in India.

I was about 57 and had completed 15 years in Emmanuel Hospital Association and had grown just slightly weary of the job. Rules would have allowed me to continue for a few more years but I wanted more from work. What will I do? Who would give me a job? Well, I thought to myself: "Take a risk; do what you like; go on an adventure; trust God; the worst that can happen is you will fail". So I determinedly decided to leave.

No inspiration for several months; busy packing and handing over. Then one day as the day of departure loomed large, I sat myself in a corner and began talking to myself: "You old fool; you will soon have to pay big bills and your last salary packet has already been paid… get proactive and make phone calls". So I obeyed. I picked up the phone and wondered whom to call. I called Christian Medical College, Vellore, and asked for the Principal. I was surprised he remembered me; even more surprised he was chirpy and friendly. (Since when, I wondered, had Vellore Principals, decided to be warm and friendly?) I told him, I had a vision; I wanted to develop the capacity of GPs in India. I tried to inject as much sincerity as possible into my voice; but the truth was that I was not sure how I was going to do that. The Principal decided to think and talk it over. A positive answer was encouraging. I went to Vellore and met the Principal and the Director. The most encouraging aspect of the meeting was when the Director said – "I am not sure what you want to do, but we know you are a good man and you are most welcome…" Little did he know that the good man himself did not know what really to do. However I knew, God was in all this and I began to think and plan furiously from that point on. I became "single minded"; Shalini my wife thought, I was obsessed or possessed or both.

How can I engage the GPs in India? How can I communicate to them? Serendipitously, I was invited to IGNOU for some workshop on environmental pollution and then happened to see the power of distance education. The technology that was being used for education was burgeoning. I enrolled for a distance learning diploma in distance education and began to absorb facts like a sponge. I was especially fascinated by the SLMs or self learning materials and the rules that help make it user friendly.

I worked out a formula for communicating with the GPs. Write wonderful SLMs and write it as "problem based" rather than as "system based". (Not diseases of the nervous system but "a convulsing child"). Use personal language, ask many review questions and provide answers. Add neat little call outs and tables and graphics. Allow much white space, so that they progress rapidly through the book giving them the illusion of progress. Package it in glossy, well-printed, seductive books. Add to it DVD lectures, video-conferencing, some hands-on experience in close-by mission hospitals and you could create a heady mixture that they cannot reject. Great plan and no money!

If Shakespeare were alive he would have said: "O, my lad, wonderful labyrinthine plans and an empty purse, well the twain shall never mix!!"

Who will fund my idea? As it so happened it was my "Gujarati" connection that helped. I had met a Gujarati Programme Officer in New Delhi working with the Netherlands embassy. I called him and talked to him like a long lost brother; initially he was cautious but I burst forth into Gujarati and the rest was easy. I took the Principal along to visit him in Delhi and finally squeezed out $50,000 from him. Then a certain Rabia Mathai from the Catholic Medical Mission agency, Washington, happened to visit Vellore and providentially, the Director introduced me to her. She recognised that we shared the

Family medicine resource books: 12 in number

Video-conference in progress

Contact session in progress

Gujarati language and it was surprising how things moved rapidly from then on. She was the chief patron of the programme and if she happens to read this article, I want to thank her.

At the age of 58 I realised that I had a gift that I had not recognised; I was actually good at speed reading, integrating, analysing and classifying. In fact I became addicted to reading material and rewriting it in simpler language and in a neatly classified way. I began to think of "pithy" call-outs to spice things up. I learnt to put down protocols in an algorithmic way. Often I used to forget it was lunch time and used to bring home my lunch box uneaten. I thoroughly enjoyed writing the family medicine material. The family medicine material was all covered in 73 problems; (e.g. an approach to convulsions in an adult) and printing it extended to 12 volumes of books. We were all set to launch the Postgraduate Diploma in Family Medicine.

I told him, I had a vision; I wanted to develop the capacity of GPs in India.... A positive answer was encouraging.... I knew God was in all this and I began to think and plan furiously from that point on.... At the age of 58 I realised that I had a gift for speed reading, integrating, analysing and classifying

We spent close to Rs 3 lakh on advertisements for the course in all the national newspapers in the country (was not easy to get permission) and then I told myself: if less than 15 people apply, I will resign and slink away as quietly as I came! One week later, no application had come. I was wondering how I could make a dignified exit. Then on the 8th day, Reena, our Secretary, said we had five applications, then on the 9th day we had 15 and by the end of 30 days, we had 500! GPs in India could be reached!

An interesting event that needs recounting: I was to fly to Delhi from Chennai in the morning and as is wont, the Air India pilots went on strike and I was left in Chennai with nothing to do for the day. I then thought to myself, let me make a foray into the Government Health Department and tell them they need the family medicine course. So I forced my way in and met Dr Davidar, who was then in charge of Health, and spoke to him about the opportunity to train Government doctors (I had not forgotten to look both sincere and professorial). He invited me later to meet a delegation that was to fund this. To cut a long story short, not only did the Tamilnadu Government accept this programme but NRHM also invited me to train government doctors in eight states. The PGDFM had now become a nationwide Government-approved programme.

Some very wonderful people joined the department: Drs Vijila Isac, who helped with initiating the writing of the diabetes material; Dr Revathy Selwyn, who helped with framing the MCQ's; Dr Jachin Timothy, who did all the rest of the work that was needed – rest of the diabetes modules, remaining videos for the courses and initiating the now very popular Lay Leaders Community Health course. Dr Anbarasi also joined the Department and as an artist-cum-family-medicine-combined-specialist, she began to review the material for the next edition. Timothy Velavan, Dr Jachin's husband, was a very well trained MBA and he brought in software and administrative sophistication to the Department.

After I left the Distance Education Department early last year, Dr Jachin Timothy was invited by WHO to Jakarta and requested to seed this course in Thailand and Indonesia.

The Nike advertisement says "Just do it"; good advice! If you have a dream, don't spend your time collecting advice. Do it! Shake off the inertia. ■

Dr Vinod Shah is Chief Executive Officer of the The International Christian Medical and Dental Association – ICMDA

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Transforming Mission Hospitals to be an Agent of Transformation

Dr Mathew Santosh Thomas

Could mission hospitals be channels of transformation? The author describes how we, as the mission network, can be centres of transformation just as the founding fathers intended, but only when we ourselves are transformed into incarnational communities of caring.

In 2001, EHA conducted an impact study. The question that was to be answered was – "Have EHA units, scattered across various locations in North India, contributed to transformation?" Even though EHA's vision statement was "Fellowship for Transformation" (later changed to "Fellowship for Transformation through Caring") it was a challenging task to define the indicators for transformation. The general agreement on transformation being holistic did help in clarifying this.

At the end of the yearlong study, the results caught everyone's attention. Transformation was evident from the stories of a few individuals who had come into contact with the institutions and the staff, but most of the transformational changes in the local communities could not be attributed to the hospital's presence alone. The limited role a healthcare institution plays due to issues related to "coverage and catchment population", the "curing and healing focus" and lack of "intentionality" were some of the potential reasons for this.

It is well known that only "transformed" or "being transformed" ministers can facilitate transformation. This is true not only for individuals but also for communities.

The questions we need to consider are – what were the objectives of establishing mission hospitals? Was it "transformation"? If so, "are we fulfilling the original mandate?" If it is "transformation", how do we understand transformation in today's context?

Some 50 or 100 years back, when most of the hospitals were established, the term "transformation" was not a commonly used one. The founding fathers were much more explicit. They were clear that the Gospel had to be demonstrated and expressed in word and deed and that that should lead to holistic life changes in the lives of individuals, families and communities. Some were much clearer – that out of all that we do, worshipping communities should be established and strengthened.

If this is the mandate – whether "transformation" as we understand it today or as "establishment of communities of worship" – the question for us to reflect upon is, "what is that we need to do to be agents of facilitating this outcome?"

The first and prime issue one needs to consider is the issue of "transformed communities" being agents of "transformation". It is well known that only "transformed" or "being transformed" ministers can facilitate transformation. This is true not only of individuals but also of communities. Unless the communities of caring or staff of our institutions are in the process of being transformed, we cannot facilitate transformation. **Recapturing the core** of what we are expected to be as "Communities of Caring" is key if we want mission hospitals to be channels of transformation. Spiritual building of staff, leadership development, intentional mentoring and support, and proactive discipleship are key to facilitate this building of communities of caring.

The first century Church was known as a preaching, teaching, praying and caring Church. People would walk into these communities and be "blown away" by the love that was showered upon them. This love was one that prepared the ground for God's spirit to bring about transformation. The question for us to reflect upon is – what changes need to happen in our midst if we are to become such "communities of caring?"

If such communities of caring are established, our **"responses"** will be **"repositioned"**. We will go beyond the

Community Awareness Programme, Nav Jivan Hospital

expected job description of professional curing to responding to the various issues that the individuals and communities go through.

Our care will become **"holistic"** and **"comprehensive"**. We will understand that every individual that walks in through our doors is an individual created in the image of God with "body, soul and spirit". Our caring systems will change to one that supports the body, the emotions and the spiritual aspects of their lives. We will start looking at the individual in the context of the family and community that they come from and will try to understand how to respond comprehensively to address issues beyond the expressed need.

We will strive to provide "excellent care" with **"excellence"** being redefined as rational, relevant, **cost-effective** and custom-made for each individual and community, but at the same time based on generated evidences.

We will constantly be aware of the emerging challenges the communities are facing and the gaps in the healthcare system, and will respond to the same by setting up programmes to respond to such issues or communities. Our **relevance** will be based on what the communities are facing and not based on what brings in most revenue.

We will also understand that the disease which the patient is suffering from or the health issue which the community is facing has much broader ramifications and contributory factors, and we will look at how to respond to the same. Addressing the **social determinants of health** would be an essential component of our caring and we would look at how to contribute to various aspects of these determinants. We will move away from being a care provider alone to building and **empowering individuals and communities**.

We will also understand that unless the world view changes, none of these changes can be sustained and we will intentionally see to it that the individuals and communities go through a value and world view change through the expressed, proclaimed and demonstrated "Good News".

This might sound like a "dream" today, but unless we hold on to this dream and start "transforming ourselves" we

Assessment of a young boy at CBR Project Awareness Programme, Duncan Hospital, Raxaul

cannot be agents of transformation.

At the same time, understanding that we are "salt" and "leaven" kept by God to bring flavour and the leavening process in the world, we should intentionally be involved in transforming community structures around us. Unless the government and community structures are changed, change cannot be sustained.

If this becomes our intentional direction, we should proactively explore how to **partner and hold hands** with all the community structures around us. CBOs, government, NGOs, churches, all should become our partners in caring for the communities we are part of. And we should partner with an intentional value change outcome perspective than from the perspective of what we can get out of these partners.

This calls for a paradigm shift in the way we run our institutions. We will need to move away from being "attractional institutions" to "incarnational communities of caring" and "missional movements" rather than "well-run institutions". In this paradigm shift, we also will recognise and build in the local church to be a key stakeholder and component of all that we want to do.

We will also understand that the disease which the patient is suffering from or the health issue which the community is facing has much broader ramifications and contributory factors, and we will look at how to respond to the same

Such a proactive recapturing of the core of what we should be – a repositioning of our responses and partnering – could go a long way in facilitating transformation through our mission institutions.

At the same time, we need to understand and recognise that the agent of transformation is God. He alone is the one who can change lives of individuals. We can only be channels through which HE can act. ■

Dr Mathew Santosh Thomas is the Executive Director of the Emmanuel Health Association.

Transformation at Makunda Christian Hospital

Brief History and Situation

Makunda Christian Leprosy and General Hospital is situated on a 350-acre campus near Bazaricherra village in Karimganj District of Assam and is at the junction of Mizoram, Tripura and Assam in Northeast India. The hospital was started by the Baptist Mid-Missions USA in the 1950s as a leprosy colony. It soon became a well-known general hospital in the area, catering to the needs of local tea estates and tribal communities. The hospital work was shut down in the 1980s when the missionaries were asked to leave the country. After 10 years, in December 1992, the hospital was taken over by the Emmanuel Hospital Association.

Present History

When the hospital was restarted, it was plagued by serious problems including land encroachment, legal (civil, criminal and labour court) cases, as well as violence and no patients or funds. Very few staff were willing to work in a remote area that had poor facilities and no electricity or water.

- It was decided to have a hospital only for the poor – there would be no private wards and no facility to see a particular doctor by paying extra. High quality would be provided at low cost to all. The hospital developed poor-identification protocols to ensure that no patient sold vital assets to finance their treatment.
- Patient volumes rapidly grew from the early days because the large number of patients found affordable and reliable treatment. In the past year (2011-12), the hospital (132 beds) has seen 87,493 outpatients, admitted 9,471 inpatients, delivered 3,535 babies and performed 1,948 major surgeries as also 97,384 lab tests, 13,039 X-rays and 6,635 ultrasound scans.
- This is the only hospital of its size in 120-220 kms all around and the only hospital offering paediatric surgical services in the states of Mizoram, Tripura, Meghalaya, Manipur and southern Assam.
- Makunda Christian High School was started in 2004 and now has 670 children studying upto class X with 220 in hostels. High quality education is offered at affordable costs to children in remote villages around the hospital as well as for the children of staff.
- The ANM School of nursing was started in 2006 and every year 25 students pass out. They are from remote rural areas in the seven states of Northeast India and are trained to be missionary nurses in their home areas.
- The large campus has been developed to grow rice, fish and

Dr Vijay Anand Ismavel

A hospital that had shut down is now thriving and that too by focusing only on the poor. The transformed hospital is transforming lives...

Nursery Care at Makunda Christian Hospital

The waiting hall at Makunda Christian Hospital on one of their busiest days...

Real transformation in remote rural communities occurs only when those who were unable to go to hospital or school are now able to do so. It is possible to get highly committed qualified staff to come to such remote areas to serve.

other produce, while preserving wildlife and biodiversity.

- A branch hospital was started in the state of Tripura (Dhalai district) in 2005 and at the time was the only Christian mission hospital there.
- Despite keeping fees low (consultation charge Rs 20/- per visit etc.) and not receiving external grants (less than 1% of income on average over the past 20 years), the hospital has been able to sustain itself as well as invest in new areas.
- A large Public Private Partnership (for MCH services) was started 3 years ago with NRHM Assam and this is now the most successful such project in Assam
- A Spiritual Life Committee oversees spiritual nurture of staff, students and visiting patients and their relatives. Some work is also done outside the campus and retreats are arranged for mission-interested students in the Northeast as well as for in-campus staff and students. Seekers are referred to churches near their hometowns and villages.

Conclusions

Over a period of about 20 years, a closed down hospital with severe local problems has grown into a thriving institution offering many services and transforming the community around it – this is only due to the grace of God and gives hope to other Christian institutions in similar situations – no institution is beyond redemption. The hard work of about 150 staff in different departments who have worked joyfully despite many constraints should also be acknowledged.

Services should be available at costs that are affordable to the majority of people living around the hospital. If this happens and the hospital is properly 'branded' as pro-poor, there will be no shortage of volumes.

A hospital does not need to have differential pricing to break even. It is possible to thrive financially by focusing only on the poor.

Real transformation in remote rural communities occurs only when those who were unable to go to hospital or school are now able to do so.

It is possible to get highly committed qualified staff to come to such remote areas to serve despite constraints. God gives happiness and contentment as His rewards to those who obey Him.

It is possible to get high quality medical results at low costs and with the facilities available in remote areas.

If good quality schools can be started by hospitals, it will provide greater transformation in the local community because these children are exposed to good Christian values over a period of 10 years. It is easier to run a school than a hospital.

Nursing and other training programmes help to transform remote rural communities when trained graduates return to bring new skills and knowledge to these communities. ■

Dr Vijay Anand Ismavel is Medical Superintendent of Makunda Christian Leprosy & General Hospital, Assam
www.makunda.in
Facebook – Makunda Christian Hospital

Transforming Social Barriers in Healthcare

Entrenched social systems and the global market ethics of today together ensure that the neediest of our people are not getting their healthcare rights. These are barriers to healthcare that need to be transformed.

Rev Asir Ebenezer

Introduction

Health is a state of wellbeing. It is a state in which different forces affecting a person/living being are held in a state of tension. These forces could be physical, physiological, plural and multifaceted, and are often complex. Healthcare then is to enhance coping by facilitating a state of wellbeing amidst the competing and compelling forces that cause a state of dis-ease while being held in tension. Bottlenecks in the process of such facilitation of coping are barriers to healthcare. These also are complex in nature and plural in number. They **can** be harnessed and transformed but to eliminate them and to envisage a time when they will not exist may be utopian.

Healthcare in India

Known for its indigenous healthcare systems, India is synonymous with holistic health. Government was the primary care provider in the healthcare system with non-governmental organisations, including Christian hospitals, and well-meaning private practitioners supplementing the government in meeting the health needs of the nation.

The global 'Health for All' campaign is said to have been best captured in the National Rural Health Mission. Whether it is a sequel to the entry of private 'entrepreneurs' to seek profits from the vulnerability of the sick, and whether an irresponsible State is hand in glove, is there for all to see. Public-Private-Partnership in healthcare is but the State playing 'Pilate' with its responsibility.

Whether it is a sequel to the entry of private 'entrepreneurs' to seek profits from the vulnerability of the sick, and whether an irresponsible State is hand in glove is there for all to see. Public-Private-Partnership in healthcare is but the State playing 'Pilate' with its responsibility.

The government is unable to seek a new and contextual role in the neo-liberal capital intensive era. It still plays the regulator, only this time in such a way that the entrepreneurs get their share unabated. It becomes pertinent therefore for all accompaniers in this mission, including the Christian Medical Association of India, to address the pitfalls and obstacles in this course of health for all.

Social barriers to healthcare

Social barriers to healthcare are essentially intrinsic to the dominant understanding and perception of society at any given point in time. They can no longer be labelled in simple terms like poverty, illiteracy, unemployment etc. Such naming can only perpetuate victimisation by possibly blaming the victim for being in the condition where s/he is not able to harness available resources to wellbeing. In today's context, social barriers to healthcare cannot but be understood as a product of the changing geo-political and socio-economic scenario across the globe with Capital ruling the roost.

Seen through this lens, a person, who hitherto was "the image of God", is now weighed against productivity; ability does not play a role. Are women, children, adolescent and young girls, the aged, the disabled and such others who are 'able' counted less on account of perceived low or no productivity? Does their health matter at all, except to be exploited to fill the coffers of the hospital on media-hyped, intensively advertised, low-cost/discounted health campaigns on special days like World Mothers' Day?

Merging with the global market is the mantra. In this context, dis-privileged peoples such as the dalits and the tribals/adivasis do not matter in the scheme of things. They become too small a number, and too fragmented, to be taken seriously. Their lives and wellbeing do not matter; they are dispensable.

Consequently, medical education is available only to the 'privileged' few who are able to gain admissions to medical colleges by benefitting from the privatised 'quality education' industry at the level of the secondary education, and those who are able to 'pay' for their medical education irrespective of the marks they secured or the knowledge they have gained. This 'select' majority, mostly from the dominant communities, comes into healthcare delivery systems with its own prejudices and biases against the dis-privileged and ostracised communities, and with regard to the constructed myths on poverty, illiteracy etc. These and their peers in the administrative services and policy making/legislative bodies, along with some in the sphere of trade and industry, create serious barriers for healthcare delivery.

Merging with the global market is the mantra. In this context, dis-privileged peoples such as the dalits and the tribals/adivasis do not matter in the scheme of things.

Dynamics and social barriers

The dynamics of social barriers to healthcare have to be viewed from the point of view of the overarching changing economic scenario where the market is no longer the servant of society but the undergirding factor of society's very existence. Within this economic framework, the value of the human and the labour that s/he brings to the market no longer has value and is now dispensable in most production processes. Governments no longer enjoy sovereign status but seek to maintain the economic balance and most times err on the side of profit.

Social barriers can thus be seen only in the perspective of demand and supply and any solution outside this ambit seems redundant. However, we who look at these social barriers from the perspective of the Christian gospel are impelled to serve and to heal (not just treat). We need to look beyond growing challenges in costs, both for care and maintenance of infrastructure – paying well to maintain quality healthcare professionals is non-negotiable; it is a requirement for basic sustenance.

Transforming social barriers to healthcare

What is essential in transforming social barriers to healthcare? The answer lies in daily search in concrete existentialist situations. At the macro level, we can identify a few spheres of intervention.

At the level of policy we need to demystify the myth of super-speciality healthcare. We need to provide super-speciality medical interventions at affordable prices to those who need it, but not at the expense of primary healthcare and preventive medicine. Weighing the numbers that need super-speciality medical intervention against those that need preventive and primary health care including but not limited to addressing conditions like malnutrition and related disorders and coping systems in the country, we might do well not to play "coping with the Joneses'" but to set a trend in addressing the needs of the masses that do not count.

Improving and rejuvenating public service and/or regulating private players are other ways by which we could address social barriers to healthcare. Public healthcare systems and institutions are systematically run down to promote private medical enterprises. Governments should transform to become regulators of society rather than facilitators of profits. Can Christian hospitals stand in the gap whilst campaigning for a global turn around? Addressing social barriers thus needs political will. We need to deal with it politically both within the Church/our medical boards and on the streets.

We need to demystify the myth of super-speciality healthcare. We need to provide super-speciality medical interventions at affordable prices to those who need it, but not at the expense of primary healthcare and preventive medicine.

Issues relating to health rights like the cost of drugs and spiralling costs of investigative procedures need to be addressed. If it is not the issue of health professionals then whose is it? Are we to only talk of curative aspects of healthcare and not prevent illness or promote holistic healthcare? A lot of us feel 'we treat, God heals'. That is so, but treating involves advocacy for the rights of those we treat so that an environment is cultured in which the treatment bears fruit. This could possibly involve a radical rethinking on who we are as a professional group – medical or healthcare fraternity. When read between the lines, there certainly is a difference.

Understanding "health for all" not by the medical intervention facility, not even by access to health, but by the wellbeing of the people could be one way social barriers could be transformed. Our health policies have to put wellbeing at the centre and then talk about the strategy and the methodology of addressing it through medical intervention centres and health promotion programmes –

we can understand this by drawing a parallel with the economic discourse seeking to replace the emphasis on the concept of 'development' with that of 'growth'. CMAI would do well to attempt an Ecumenical Health Policy where wellbeing and not medicine is at the core.

Conclusion

Addressing social barriers to healthcare, therefore, involves 'transforming/revolutionising health care systems to address social barriers' to accessibility and training so as to perpetuate healthcare from and within communities, and also to monitor it for efficacy and impact.

Focussing on culturing health rather than on mere medicinal intervention, drawing from the experience of dealing with people living with HIV/AIDS and in the field of psychological medicine where just ARTs and psychotropic drugs alone are not employed, can address social barriers to healthcare.

Going to the people is essential in addressing social barriers to healthcare. People fear, and are overwhelmed by, healthcare delivery centres. Learning from the people and amidst peoples (community based training) could be a healthy movement away from institution based learning. In this way people will be involved in devising their health and wellbeing – no one hat fits all.

These could be a tall order. Yet it is important to dream. The Christian hospitals have the potential and commitment to provide the breakthrough. It was heartening to note at least one senior healthcare professional encouraging Christian Hospital Administrators to involve in alternate systems of healthcare delivery (not dispensing) in the context of drawing the master plan for the Chithoor campus of the CMC Vellore Association. We have reached the end of the tunnel. Let us embrace the light with boldness and shine forth. Let us transform the philosophy and dynamics of healthcare in order to transform social barriers to healthcare. ■

Rev Asir Ebenezer is a Medical and Psychiatric Social Worker and an ordained Minister of the CSI Diocese of Madras. He is Finance Secretary of the National Council of Churches in India.

For All to See

Transformational Effect of Community Service

Dr George Varghese

I think that the transformation of an individual or a community is a process. "Being transformed" from one state to another, either positively or negatively, is happening all the time. There are always some things that need change either in an individual or in a community both within and without. Positive and healthy change is a call because of a higher reason. The reason for change captures our attention through someone or something, then our hearts and minds are moved and we choose to 'become' different. Many would need help to make this move. A better quality of life is embraced after discarding the poorer life. Transformation of an individual or the community will have a ripple effect. These transformations can be:

- From addiction to grace
- From selfishness to service
- From sickness to shalom
- From fear to love
- From bondage to freedom

And so on. All these are processes. Some take years, only for the person to find that there are other areas, within and without, waiting for radical change.

In the context of Christian community service, opportunities for such changes are enormous. A person who is interested to see such transformation will have to be patient and kind. They will need to manifest genuine love and empathy in the place of their calling. This will encourage

It might be that it is something small and easily addressed that is impeding the transformational experience

those around to enquire, and this in turn will disturb the status quo. Through this process the service provider will also get transformed.

Questions to ask ourselves:

- What are the areas in my life that I desire change in?
- Why do I want to change?
- If I change what will I look like? What impact will it have upon my relationships?
- How far am I willing to let go to be transformed?
- What are my inhibitions and fears?

Questions for the community:

- What are the damaging practices in the families of the community that affect their individual and collective lives?
- What are the steps we need to take together? The initiative needs to come from the community after discussion and dialogue.
- What is the timeframe and is there a commitment to stay on longer to give advice, direction and support?
- In the midst of social change there will be some who are seekers of inner peace; will they find someone who will help them in their journey?
- How prepared are we to encounter such a person and become a 'friend'?

A semi-orphaned child sitting in the corner of the room drew my attention in one of my visits to Spiti. She had recently lost her mother in an accident and her alcoholic father did not care for her. As a result she and a friend were brought to live with us in the clinic (with a friend). The child, three years old and sadly withdrawn, was restless and as I sat next to her I noticed that her hair was laden with lice. She could not sleep at night because of the itching and had no energy to play in the day time. After two days I managed to get someone to deal with her lice. Within a week she became an active, happy child who then moved to my friend's family and became part of it. But this event bothered me and gave me the desire to do something for children in Spiti. We got help from friends and built a 'health' oriented preschool. We looked for three local girls and sent them for teacher's training and eventually started a preschool with about 30 children. It became a 'model' anganwadi. Here we teach basic hygiene to inculcate good health habits like washing hands, brushing teeth, combing hair, cutting nails and blowing nose, as well as providing an environment where children can learn and play.

The Government Child Welfare team visited us. They requested us to train 50 of their illiterate anganwadi workers. Our teachers hold workshops to improve their skills. As of today, there have been many workshops and slowly the situation is improving. Nevertheless there is a long way to go to bring about positive changes in the habits of these children. Our teachers visit the children's homes regularly and talk about nutrition and behaviour-related matters with the parents. The parents take turns to bring mid-day meals for the 30 children and the changes seen in the children are amazing.

It is a small beginning with 30 children. They will go to other schools by the age of 6 but some basic foundation in good habits has been laid. No doubt, long term benefits to their health will result. The teachers work hard to give these kids an enquiring mind, and in an atmosphere of love they become creative and enquiring individuals. Social skills are developed at an early age and above all stories of the "wonder man Jesus" are told every day. Songs are sung which I believe will stay with them for a long time; someday it will awaken their spirits. We believe we have vaccinated them with the truth at some deep level and trust transformation will take place in its own time. ■

A photograph, taken two years ago, of Khando of Mane village in Spiti Valley

Within a week she became an active, happy child who then moved to my friend's family and became part of it

Dr George Varghese is former director of Rural Based Community Care – RBCC. Of the three projects he set up, he is still involved in Mudgran in Lahaul Valley and Kaza in Spiti Valley

For the Least of These

It was the best of times, it was the strangest of times; It was a time of vulnerability... It was the right time, a time of healing, hope and transformation. It was a time of change...[1]

Across the world, one sees several awesome wonders under threat by humanity's destructive nature. We seem to prefer to hunt, hurt, neglect or maim those weaker than us, rather than help them, forgetting God's Word in Genesis 1:26-28 and Matthew 24. But the work of the Coles and of Rev Dr Fowler invites us to examine our treatment of 'the least of these'.

Recovering substance abusers,[2] Garvin Cole and his wife noted the absence of residential programmes for women substance abusers in Trinidad and Tobago, and became the change they wanted to see. With their own in-depth knowledge of the 12-step AA Programme[3] and a desire to change lives in Trinidad and Tobago, they bravely opened the doors to Serenity Place in March 1996, despite an absence of electricity or piped water. Their primary aim was clear – offering an alternative lifestyle through residency rehabilitation to female substance abusers.

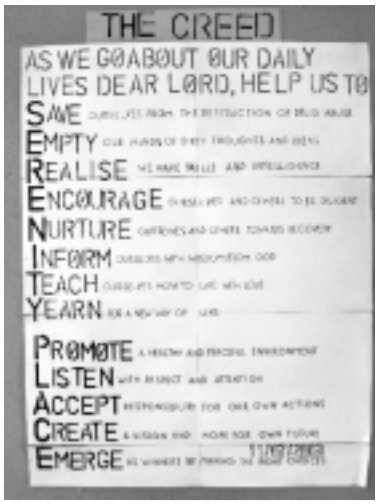
In becoming the change they wanted to see in those women, the Coles did not expect that of their eight residents, almost ALL were survivors of domestic abuse turned to drugs and/or alcohol to forget/drown their problems

The parable of the 'Good Samaritan'[4] comes to life in the Coles' story, as they were once the 'dregs of society' – the undesirables in polite company. Substance abusers are often burdens to their family and friends, because in their need to get another 'fix', they sometimes steal from everyone and will do anything. They are often unable to control their actions and are sometimes objects of scorn and pity. Several persons in the Caribbean are likely to see them and wonder why they choose to 'throw their lives away' with liquor and/or drugs; but very few of us are interested in hearing their story or providing much-needed help. In becoming the change they wanted to see in those women, the Coles did not expect that of their eight residents, almost ALL were survivors of domestic abuse turned to drugs and/or alcohol to forget/drown their problems.

But ministry to these socially unacceptable women was to provide a fresh challenge for the Coles, despite their training as social workers. This added reality required a different approach with regard to the security, protection (from their abusers) and rehabilitation for the women. But, they persevered. Assisted by a Roman

Rev Nicole Ashwood

One report suggests that the Caribbean has perhaps the highest collective reports of gender-based violence. Many of these women go on to fall off the societal map. Two centres – Serenity Place and Theodora House – offer hope to such women, thus transforming their lives.



Vision and Mission of Serenity Place – note the acronym

Residents of Serenity Place just before a session; the baby is also a resident

Catholic congregation in the community, they began to make the necessary provisions for self-sufficiency at Serenity Place. And since then, they have – with some governmental and church assistance – ministered to over 300 females, some barely at the legally accepted age of consent.

The name Serenity Place speaks to the motto 'Inner Peace' and is a

> *centre for empowerment … supporting the successful re-insertion of the "victims" into mainstream society as productive citizens, not hiding them and perpetuating their powerlessness. [We] include skill building and we pursue available services offered by the government to assist our residents to rise above their debilitating circumstances.*[5]

What makes this programme outstanding is the fact that it does not judge, condemn, or force religion upon the women who enter its doors. Because, for the founders it is more important to be a space '… based on the principle of "(Wo)man helping (wo)man to help herself". In all that we do we put God first and we encourage our residents to find the God of their understanding and establish a personal relationship with Him. For those who find this difficult or who may not know God … we point the way to Jesus Christ.'[6]

In a similar way Rev Margaret Fowler, a Scottish-Jamaican minister, found herself constantly burdened with a desire to discover the real stories of the "Ladies-of-the-Night" in Negril, Jamaica. She decided to visit the places where they were – bars, clubs and 'dancehalls'. She ministered to the prostitutes she met in small ways: she bought them drinks, she earned their trust, she offered them condoms and a listening ear, she was kicked out of several clubs when the owners realised that the 'crazy white woman-pastor' was threatening their profits by helping their 'girls' to become independent.

When Rev Margaret Fowler heard and saw similarities in their (prostitutes') stories, she contacted her friends and connections near and far and asked for their help. This gave birth to the Theodora House

When she heard and saw similarities in their stories, Rev Margaret contacted her friends and connections near and far and asked for their help. This gave birth to the Theodora Project[7] and later Theodora House, which was to

> *… house students who are sexually exploited and at risk of human trafficking. Shared Hope International continues supporting the Theodora Project in this venture to provide vulnerable students a safe environment to live and participate in a two-year program which includes community living and all aspects of personal social development.*
>
> *The Project has completed one three-bedroom house which is situated adjacent to the Theodora Center. The safe house is available to accommodate students from the Project who need to be relocated from their present undesirable situations. The wider community will benefit from an overall safe house for women who are suffering from sexual violence and who may become potential trafficking victims.*[8]

These women, like many in the Caribbean[9], were primarily victims of Gender-Based Violence, which according to the UNFPA

> *…both reflects and reinforces inequities between men and women and compromises the health, dignity, security and autonomy of its victims. It encompasses a wide range of human rights violations … Any one*

of these abuses can leave deep psychological scars, damage the health of women and girls in general, including their reproductive and sexual health, and in some instances, results in death[10].

Matthew 25 challenges each of us to become the Good News to the least of these, to treat them as HUMANS, rather than objects of scorn, fear or pity. In their daily lives, Margaret and the Coles were able to see the least of these, to claim them as HUMANS, "*transforming lives that were once considered lost and hopeless by the society*"[11]. ■

Rev Nicole Ashwood is Education in Mission (executive) Secretary with the Caribbean and North America Council for Mission

Sources

Brochure on Theodora Project (Negril, Jamaica) – 2010

National Strategic Action Plan on Gender-Based Violence – Bureau of Women's Affairs (Jamaica) 2010 draft

Interview with Garvin Cole – Founder and Director, Serenity Place (Trinidad) May 2012

For further information:

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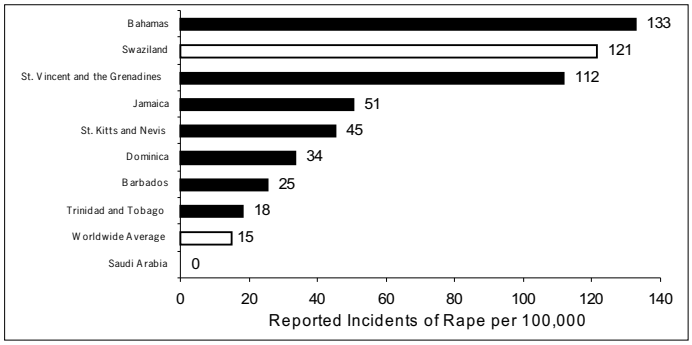
Appendix 1

Rape Rates in Caribbean and Comparison Countries



Source: Crime Trends Surveys – United Nations (various years) in *National Strategic Action Plan on Gender-Based Violence - Bureau of Women's Affairs (Jamaica)* 2010 draft.

Footnotes:

1. Adapted from Charles Dickens' *A Tale of Two Cities* opening lines.
2. Substance abuse includes alcohol and drug use, but may include the extreme of any 'substance' which has long-term harmful effects on the body.
3. Alcoholics Anonymous is an organisation which helps alcoholics to name their addiction and move toward becoming 'normal' members of the community once more.
4. In Luke 10:25-37, Jesus makes an illustration of what it really means to love our neighbour by speaking of a man who rescues a fallen man, even though he was from 'enemy territory', while the religious people of the day ignored the fallen as they went about their regular routine.
5. Serenity Place description – Garvin Cole May 2012.
6. Ibid.
7. Theodora was the wife of Emperor Justinian who ruled alongside her husband and saved the empire during the Nika Revolt.
8. Theodora Project description – May 2012.
9. According to the reporting group on criminal activities worldwide, Crime Trend Surveys (CTS), the Caribbean region has perhaps the highest collective reports of Gender-Based Violence. In the statistics provided on reported rape cases for example, there is indication that, "*all countries in the Caribbean for which comparable data are available experienced a higher rate of rape than the unweighted average of 102 countries responding to the CTS: 15 rapes per 100,000". (See Appendix 1)* sourced from Conflict Vulnerability Analysis, Issues, Tools and Resources, USAID, 1999, p3 in *National Strategic Action Plan on Gender-Based Violence - Bureau of Women's Affairs* p. 3.
10. Ibid p 20
11. Garvin Cole speaking about Serenity Place.

FROM OUR ARCHIVES

The Journal of the Christian Medical Association of India,

Burma and Ceylon

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National Missionary Society

Ten years at Puram

At Puram in N.Arcot the N M S began work ten years ago. The L M S had worked there before and there were three Christian families. There are now eight. Miss Jeyamoni Taylor was the first missionary; there are now four, three women and a man, and other workers – eleven in all. Of the medical work the following is the report:

Medical work. From the very beginning the villages were in need of medical relief for simple diseases. The Ashram at Tirupattur helped with a supply of medicines to begin with. As time went on we realised the need of a trained medical helper for women and children. The voluntary service s of Miss H R Bradley were very timely. She developed the medical work for two years as far as was possible in a village within our limited resources. She started Maternity and Child Welfare work. The mission house where the medical work was started was inadequate and so a house was rented for this purpose. In 1930, a Child Welfare building was constructed at a cost of Rs. 1700. There is no compound wall to keep the front verandah clean and protect the small garden from animals. It is very necessary to have a compound wall around the Welfare Centre and finish the bath room, which will cost about Rs 200.

Transformational Ministry of Fellowship of Baptist Churches


Mr M Selungba Singh

Transformation can happen as a result of ministry within a church and among churches, collectively. The Fellowship of Baptist Churches, Silchar, Assam, is a good example of this.

The Baptist Mid-Missions (BMM), with its headquarters at Cleveland, Ohio, USA, began its missionary work in the Northeast region of India in the 1930s in the form of medical evangelism. They settled at Alipur, Cachar, Assam, on a permanent basis in the 1940s and gradually established centers at Jaffirbond, Makunda and Binakandi areas of Barak Valley. In the 1950s, Burrows Memorial Christian Hospital at Alipur, and Makunda Leprosy and General Hospital at Makunda were established. People of this region as well as neighbouring states of Manipur, Nagaland, Tripura and Mizoram heard the gospel from them and came to know the Lord and the few churches were established. On 5 November 1959, the Fellowship of Baptist Churches (FBC) was formed at Alipur with five churches. The founding members were all nationals and the missionaries guided and helped them in administration and ministry. It was organised on the concept that the Holy Bible, which is the Word of God, is the sole authority in matters of the faith and practice of believers and that Lord Jesus Christ is the Head of the Church.

BMM missionaries helped the national believers and Church leaders, teaching and guiding them in the different fields of ministry which included medical matters, evangelism, literature, Bible School, church planting, education etc. FBC appointed evangelists who went out to the unreached in far-flung areas of these states. The Word of God touched the hearts of many people. They were convicted of their sins, confessed and accepted the Lord Jesus Christ as their Lord and Saviour. In this way, through the ministries of FBC, thousands of souls were transformed including many nominal Christians. Gradually, many churches were established. In 1968, the FBC was registered under Societies Registration Act, 1868, as a non-profit, charitable society. The FBC extended its ministries to the neighbouring countries of Nepal and Bangladesh. At one time, the number of churches grew upto 60. Some of the churches withdrew from FBC due to various reasons. As of now there are 38 churches on the roll from the states of Assam, Manipur, Nagaland and Meghalaya. Members of these local churches are from about 15 different communities. These churches are small in size but firmly believe and stand in the promise of God as written in Luke 12:32, “Fear not God’s little flock for it is the Father’s pleasure to give you the kingdom.”

Over and above evangelism and church planting, the FBC is concentrating on strengthening the churches. Fellowship is teaching the Word of God and training young people in Bible colleges and seminaries, short-term Bible Schools, camps, and retreats. These activities have always resulted in finding and training new leaders for the strengthening and growth of local churches. Despite all the difficulties, the Lord has indeed helped the fellowship. His loving and caring hands have been continually upon this fellowship. This we have seen and experienced during these fifty years’ life of the fellowship. We give all glory to Him. ■

Mr M Selungba Singh is General Secretary of the Fellowship of Baptist Churches at Court Road, Silchar, Cachar, Assam

FEATURE

Whole Person Care
A Tool for Transformation in a Mission Hospital


Dr Latha Mathew

Transformation is empowerment and Whole Person Care (WPC) is one way mission hospitals can bring about empowerment. The Duncan Hospital, Raxaul, practices WPC to bring about transformational healing in the lives of its patients.

The Duncan Hospital situated at the Indo-Nepal border was started 82 years ago by a Scottish missionary doctor named Cecil Duncan. It was handed over to the Emmanuel Hospital Association 43 years ago. We offer healthcare to a population of more than 2,50,000. The Duncan's vision is to offer excellent holistic care to people living in Bihar and Nepal with a focus on the poor and the marginalised. To justify the very name "mission hospital", we exist to demonstrate and proclaim the good news of God's love.

What is WPC?

The Emmanuel Hospital Association identified the need for the Whole Person Care approach to bring transformation in the places where its hospitals are situated. This is the attitude of treating every patient as a person in need of physical, emotional and spiritual healing. The Duncan continues to touch lives of its patients through this simple yet powerful approach. This has been the uniqueness of working in the Duncan Hospital.

Why WPC?

As a hospital, we have some crucial fundamental things to consider in our work.

Jesus in His Nazarene manifesto (Isaiah 61:1,2) mentions the physical, emotional and spiritual healing that He came to offer. This was Jesus' model of healing people. In Mark 5:25-35 in the healing of the woman with the flow of blood for 12 years, Jesus addressed the physical ailment (bleeding stopped), the emotional problems (calling her "daughter" as well as listening to her story), the social issues (accepting her as clean in front of the whole crowd) and the spiritual needs (assuring that her faith had healed her). Jesus never reduced man to only a physical being but saw him as a complete being made in the image of God. ***The Bible thus explains disease as multifaceted and interrelated; something that has physical, emotional and spiritual causes***. We want to be in step with the Master Physician in our approach to patients.

We come across many patients who live under the **burden of guilt of sins** committed in the past. This varies from stealing, to murder, adultery, abortion, pre martial sex and extra marital relationships. They are chronically ill and keep seeking medical help. Year after year they get treated for physical problems when the root cause is spiritual. Even when the body is apparently healthy these people are burdened with the heaviness of guilt. ***Who could offer them healing other than us who know the one who forgives sins?*** Here is the story of one of our own staff at the Duncan Hospital.

Rev Bagh of the Chaplaincy / WPC team shares:

"One retired staff kept asking me if he would go to heaven. He then went on to confess that he had deceived one of his colleagues many years ago. The colleague had been punished instead of him. This thought constantly troubles him. He also admitted to having committed other mistakes which had left him disturbed in the spirit even as he felt weak and heavy in the body. I advised him to write down all his mistakes and repent before the Lord Jesus and then burn the paper. He did as was suggested to him. Later when the team visited him he was a different man."

Every disease may not have a spiritual root cause but almost all the patients are prey to **emotional problems**…. Fear, anxiety, bitterness, jealousy, conflicts in the family, lack of love between husband and wife, unemployment, poverty, struggle to meet the basic needs of life – the list is never ending. The question we had to consider was "***Are these***

The WPC Team at Duncan Hospital, Raxaul

Sitting (left to right):
Dr Latha, Rev Bagh, Mrs Aruna

Standing (left to right):
Mr Jeevan, Dr Geogy, Dr Prashanth

patients healed when they leave our hospitals? How can we send them off by treating only a part of the person?"

There are many patients who have found help for their emotional problems – fear and family problems being the most common.

A 28-year-old lady came to our hospital complaining of fever on and off for two years. She was admitted and was undergoing treatment. The team visited her and she shared her struggles. A married lady, she had difficulty conceiving. She was not accepted by her husband's family due to which she had to face difficulties. She was feeling lonely and unloved. We then talked to her and her husband about how the problems in the family were affecting her health. We prayed for her and she came after a month again. By this time she had conceived. They went back acknowledging that this was the work of God in their lives.

How do we practice WPC in the Duncan Hospital?

As a hospital we know our relevance is in seeing transformation around us. This is the reason for our existence in this remote part of India. Can we solve every problem of all the patients? Of course not!! But to do nothing at all is both unethical and a mediocre practice of medicine.

The Whole Person Care is not a programme or an activity but an attitude of the heart. The Duncan Hospital tries to offer WPC to our patients through various means.

To begin with, this is the approach with which we treat patients.

- We have **a team** who visits patients and **listens** to their stories whereby patients are able to share their life struggles. Their physical recovery quickens due just to the fact that someone listened to them. This is an opportunity for people working in departments that do not come into direct contact with patients to be a part of the healthcare team.
- Doctors refer patients who specifically need to be given more attention to the team.
- Nurses report to the team of patients with key areas of need we have identified. For example patients who have attempted suicide, acute conversion reactions, relatives of patients admitted in the ICU and mothers who lost their babies during delivery.
- We also have a training session every Thursday for staff emphasising listening skills.
- We meet once a month as a full team to share our experiences and pray for our patients.
- The Chaplaincy Department also visits our staff and listens to their struggles.
- The Community Health and Development team are also trained to offer WPC.

Listening is the key factor of WPC. Listening brings healing better than well intentioned words. We then offer help in various ways. It could be a loving gesture, a kind word, prayer for them which often ends in the sharing of the Gospel. Attempts are being made to link the hospital staff, the Community Development Team and the local churches so that we may be united and work toward bringing transformation to our people and establishing the Kingdom of God in this remote part of Bihar. We as a hospital have miles to go in our approach, but we are on our way….

We are amazed at the impact we can make in the lives of our patients through this small yet powerful tool. We see people going back free from guilt, families being restored, many finding meaning in life and being able to cope with and find peace in the face of unavoidable struggles. The Lord

has also enabled us to see some people accepting Christ and being added to the Church!!

Mrs Aruna of our WPC / Chaplaincy Department shares the example of a patient who had been sick over the last one year and was admitted to the hospital. She became better but never experienced complete healing. She was recently again admitted to the ICU in a critical state. We visited her regularly and over time she opened up to reveal her story. She had been suffering from headaches, tingling sensations, palpitations, and abdominal discomfort and more than that she had guilt feeling. Moreover since a few months she and her whole family kept seeing the same dream and this had left them fearful. We asked her and her husband what they thought the reason for the happenings was. And this was their response, *"We recently built a new house, but we feel that house is not suitable for staying as the registry was done on a Tuesday, not an auspicious day. We should have done it on a Thursday, a day suitable for any good work. So we want to leave this house and shift to another place."*

They spent a lot of money on her treatment over the last one year and her husband lost all hopes of her being healed. Moreover, one of their sons who sang well, tried to launch his music CD for which the parents had spent Rs 1,00,000 but that too failed. The team prayed with them that they be delivered from all their fears as well as seek success in their son's endeavour. Two weeks later they came back very happy and shared with us the miracle God had done in their lives. They now believed that Jesus had done this for them. We gave them a Bible and we invited them to the church. They now attend church regularly and even gave their testimony in the church.

Who can Practice WPC?

Whole Person Care is an attitude that anyone can easily adopt. The only requirement is to have personal experience of the love of the Lord Jesus Christ and a heart to listen to people's struggles. This can be practiced by individuals, departments, institutions and organisations. This is an opportunity to practice our profession in the true sense and to bring health and healing to our patients. Let us practice medicine with excellence and an approach that focuses on the whole person. ■

Acknowledgments: Rev G Bagh, Chaplain, The Duncan Hospital & Pastor of Raxaul Christian Church, and Mrs Aruna Singh, Evangelist, The Duncan Hospital, Raxaul

Dr Latha Mathew is Coordinator of the WPC at EHA and is also Head of the Dental Department at The Duncan Hospital Raxaul, Bihar

TRANSFORMED LIVES

Transformation amid HIV & AIDS

Dr Saira Paulose

(Names changed to protect identity)

Sometimes a health crisis in the life of a loved one could incubate the transformational experience in one's own life

Indian tradition frowns upon its people going for inter-caste, inter-linguistic or inter-ethnic marriages. Breaking all barriers of language, culture and ethnicity, Dharmesh, a very young boy from Punjab, married Tinku, who was from Calcutta. This was the 1970s when inter-caste and inter-state marriages were a very big issue. In fact, they are a big issue even today. Every now and then we read about honour killings that still happen in our country.

Dharmesh and Tinku were happy in their married life. They were blessed with a baby daughter. Their marriage lasted more than 35 years and ended with the death of one of them.

They decided to settle in Delhi as this big city provides several opportunities for better jobs, better payments and better lifestyles. Chances of giving their only daughter a secure future were also better in Delhi than either in Punjab

or Calcutta. He worked as a driver and she had a job in a local factory. Their daughter is married now.

They appeared to be a very regular, normal, happy family until two years ago. Dharmesh began to fall sick often with nail and throat pain. He began to get ulcers. This was a big concern for the family. When they took him to the hospital for treatment, he was diagnosed as HIV+.

This was a big shock to Dharmesh and the entire family. The extended family distanced itself from him. This took a toll on him. Emotionally he was very disturbed. He began to withdraw both from family and friends. He avoided going out and felt as though he had lost all sense of identity.

He was put on ART medicines from Deen Dayal Upadhyay Hospital. A couple of doctors who work there (Drs Charu and Kalyani) spoke to him about visiting us at Shalom. They came to Shalom and have been enrolled in the Home Based Care programme (HBC). They received a lot of counselling and moral support. Shalom also provides some monthly provisions for them. They are thankful for the work of Shalom.

Dharmesh has been without a job for almost four years now. He was paralysed and also very weak. Tinku's earning from the factory job is what kept them going but this was not sufficient. Dharmesh's one desire or hope is that he will get better soon and be able to work again and provide for the family. After prolonged treatment, Dharmesh is able to walk with the support of a walker.

They were no longer the happy peaceful family. Dharmesh had become very irritable and angry and fought with Tinku constantly. She had no peace of mind. She was HIV negative and that was a big relief for her.

The year after introducing them to the church, Tinku came to Shalom and shared with the HBC team that she had finally taken baptism

Since the time they were enrolled with it, the HBC staff continues to visit them and pray together with them. During one of the regular visits, one of the Shalom HBC staff shared her own testimony about the true God who saved her life. One day, as the staff came to visit them, Tinku asked the staff if there was any church around so that they could go and pray. The staff introduced them to a church nearby who knew about Shalom's work among the PLWHA. They gladly welcomed both Dharmesh and Tinku. The year after introducing them to the church, Tinku came to Shalom and shared with the HBC team that she had finally taken baptism. The pastor and our team visited them regularly.

Dharmesh and Tinku love each other so much that each time we meet them they confess that they won't be able to live without each another. Broken hearted she may be to see her husband's condition but she vowed to support and care for him till her last breath. She kept the promise and till her last breath she took care of her husband.

Tinku was diagnosed with a late stage of ovarian cancer and she died in a government hospital some months ago. The Shalom HBC team visited her and prayed for her and her husband in the hospital. In her last days her sorrow was transformed into peace through her faith. Finally in March 2012, she left this world to rest in peace in the Lord. The Shalom team and church volunteers were present during the cremation. The church continues to support Dharmesh. ■

Dr Saira Paulose is Project Director of Shalom in Delhi

The Transformers

Transformation is a communal experience and must touch both the giver and the receiver; else it is mere controlling and exploitation. We must transform ourselves to prepare for the healing ministry.

Mr Anand Peacock

Identity answers the question, 'Who am I?' Dignity answers the question, 'What am I worth?' And transformation answers the question, 'What am I to become?'[1] Time and again we have understood identity, dignity and transformation in terms of the self and not relationally in terms of community; as a result much Christian spirituality has moved from the realm of the people to the sphere of the individual. When our understanding centers upon the self, our discussions, efforts and biblical interpretations chart out a self-indulgent path. Thus the Christian world view renders the God of people into a God of wonders beyond the galaxy, who can only be felt and experienced in "personal" terms.

When the Christian ethos centers on community (since God has person hood and is three persons in one) we can converse in a language where identity and dignity are not just a personal affair but dwells in communities, we can talk of transformation of the community in the same way as we talk of the transformation of persons, it is a movement from the exclusive to the inclusive from the "me" towards "we".

When we contemplate community transformation we are entering into the cleansing and recovery of institutions[2]. (I am not initiating a discussion on where institutions have fallen short and how they can be revived and transformed since I firmly hold that each system ought to map its own course according to the needs and vision of the people within its given context; to offer universal solutions may be unsolicited). There can be social transformation when there is an essential transformation of institutions. Perhaps we have overemphasised personal transformation to such limits that we have downgraded community transformation as a secular venture of social work organisations. The age old belief of changing the world begins with me is habitually overplayed. Exaggerated round tables on self transformation have heightened the feel good factor but offered no considerable affect in community change. Yet, sometimes in the process of change, (the inclusive) our personhood itself undergoes transformation.

Among the diverse experiences in the country of Malawi, one that I can relate to in this process of transformation is an occurrence that went beyond the confines of a classroom. In my interactions with a fairly large class of 75 students, on one occasion I reached the limits of my patience when I felt strongly convinced that they were unable to grasp simple concepts which I pored over in demonstrating to them. I left the class in abhorrence and vowed not to return if they chose to be unresponsive. One young lad among them walked me out of class and spent time explaining their extant struggles to me, which was more an exercise in humility and enlightenment. Apparently, independent thought had not been encouraged; consequently the lay Malawian was expected to parrot whatever had been taught and handed down to them from the Missionary. The world view that was promoted was not culture specific, instead it was a Western world view (not to belittle Western theologies which have dominated much theological scholarship the world over). Since religion is a private affair in Western theology how it relates to the larger sphere of life is a question seldom asked. Religion in the "Dark Continent" is a community event, not private. This young man encouraged me to return the following week, with persistence that there would be change even though I may not witness it readily in ways I chose to recognise. I did return, with the intent of allowing myself to be part of the process, rather than be an impediment, and with time there was a steady exchange of growth and change in both our world views.

This is precisely what transformation does; it changes both the receiver and the giver to the degree that the distinction becomes blurred. Any transformation that dramatises changing the target group with little regard for being transformed itself runs the danger of being controlling and exploitative. It practices a system of communication

that flows from power to weakness. This may offer quick visible results and hold documented evidence but may lack the twofold effect that true transformation carries with it: empowering the recipient and changing both the giver as well as the receiver.

Where could the Church mediate in this progression of transformation? All too often the theology of the Church has remained just that, a Churchy theology which has paid modest attention to the aspect of transformation since Church theology usually avoids internal conflicts with the oppressing social and political powers in society.[3] If by social transformation we could imply racial discrimination and inequality, the Church has not only been silent thereby underlining her audible stance, but has been guilty of perpetrating such inequalities within the relationships dwelling in local congregations. You may be aware of how the Church has even justified inequalities with ecclesiastical firmness in countries like South Africa.

To recommend a theological solution: a balance of love and justice would be appropriate, being aware that our focus ought to be more on love than on justice;[4] *love without justice runs the risk of growing sentimental and irrelevant, while justice without love becomes uncaring and judgmental*[5] besides altering into a mere political statement; yet justice is immanent in love and does not transcend it and therefore we stress more on love than on justice.

The author, who worked in the land of Africa (shown here), reflects on the theme of this issue of CMJI

We need to move from a theology of liberation to a theology of transformation, where the Church would recognise that while she is central in establishing alternate systems of the Kingdom she is not the sole actor. It is not enough to set people free from chains of oppression, we need to move from an unjust society to a just one to dare to change and be changed ourselves, to fill up the valleys and also descend from the mountain top. (*Isaiah 40:4*) ■

Mr Anand Peacock has just returned from Malawi to India after teaching at African Bible College; he is currently awaiting admission for a PhD in Mission and Development in South Africa.

Footnotes:

1. In his Oxford lectures Vinay Samuel brings to light some of these concepts in terms of community. Here we refer to his works compiled by Chris Sugden (Identity and Transformation The Oxford Lectures of Vinay Samuel 1998-2006 in Identity and Transformation *Transformation* /3 & 4 July & October 2007 p 133-136)
2. Sugden, p.138.
3. Oliver Byar Bow Si, *Mission as Transformation: An exploration of the relationship between Mission and Development* International Review of Mission Vol. 97 No. 384/385 Jan/Apr 2008 pp 92 - 102.
4. David J. Bosch, *Transforming Mission: Paradigm Shifts in Theology of Mission*, York, Orbis Books, 1992, pp. 402-03
5. Duncan B. Forrester, *Just Sharing: A Christian Approach to the Distribution of Wealth, Income and Benefits*, London, Epworth Press, 1988, pp. 77-79.

Humour

The 600-Storey Hotel

Tom, Dick and Harry went to a party. After the party they returned to their hotel. The hotel was 600 storeys high.
Unfortunately for them, the elevator was not working.

They made a plan – for the first 200 storeys, Tom would crack jokes.
For the second 100 storeys, Dick would have to tell a happy story and lastly Harry would tell a sad story.

They then started up the steps.
After two hours it was Harry's turn. He turned to the other two and said, "OK guys, here's my sad story. I forgot the keys downstairs."

Source: **www.cleanjoke.com/humor/Funny-Stuff-Short-Jokes.html**

"When I read the Sermon on the Mount I burst into tears"

The word of God transforms. Even in the face of death it has the power to render peace and strength. And who is to say that the final few days spent experiencing transformation are any less precious...

Dr Stanley C Macaden

The title of the article is what Mr KS said during one of our palliative home care visits. It left us, as a team, amazed at the transforming impact of the powerful words of Jesus. Mr KS's reaction also challenged us to introspect if the Sermon on the Mount ever moved us to such an extent!

Mr KS had advanced liver cancer and was referred to the Bangalore Baptist Hospital Hospice and Home Care team for palliative care. He was a very learned, erudite, Hindu Brahmin, who had retired as a senior executive of the Central Government. His family was also very educated and caring in every way. His house had beautiful paintings mostly depicting some thought from Hindu mythology. In our initial visits, Mr KS would praise his daughter who had done some of the paintings and also explain to us the meaning of them. We always listened and appreciated his conversations. At the end of our visits, as a routine we prayed with him with his permission. A relationship of trust and mutual appreciation was established.

We remain grateful that Mr KS had experienced Jesus and that God's Holy Spirit had used the soul-saving words of our Lord to transform our dear friend KS

During one of our following visits, Mr KS seemed worried and sad, and on enquiring he began explaining. He said that in his area of work there was an important matter pertaining to safety which he had wanted to implement and make mandatory by law but was unable to do so. After acknowledging his sadness, I quoted Jesus' words from the Beatitudes – "Blessed are the meek for they shall inherit the earth". Mr KS was perplexed (so was I) and wanted to know what this meant. I explained that while he had the authority, he could have made the important ruling and thrust it on others. Instead he kept emphasising its importance and waited for others to be convinced. Since it was an important safety issue it would one day become mandatory by law. Then people would remember how he used to emphasise it and did not force them into it. In that sense, he had inherited their love and respect. Meek does not mean being weak but strong enough to hold one's convictions and allow others to also realise the truth in them without using force. Mr KS was so comforted and gripped by these powerful words of Jesus that he wanted to read the whole of the Beatitudes. We gave him a copy of the New Testament. This then went on to wanting to read the full 'Sermon on the Mount'. Later during one of our home visits he made the title statement of this article. It was quite clear that he had been touched by our Lord Jesus and His powerful words were transforming him. In a subsequent visit he asked giving an actual example of a famous religious head convicted of murder as to how he could receive God's forgiveness. We told him about one of the thieves crucified with Christ and how he had received instant forgiveness on repenting of his wrong doings and acknowledging the Lordship of Jesus.

Mr KS touched by Christ, continued in his newfound interest in understanding the Sermon on the Mount. After some days when he had become very weak and unable to sit and read the Bible he requested us to tape the Sermon on the Mount and give it to him so that he could listen to it while lying down. We wanted to take his daughter's permission before doing this but were unable to do so as she was away on work and important meetings. However we prayerfully recorded the Sermon on the Mount on one side and some well-loved Gospel songs on the other side and gave it to him. It was a tremendous moment for us as a team to sit beside the now very weak and bedridden Mr KS and listen to our Lord's sermon together! As we finished listening to chapter 5 of Matthew's Gospel we were wondering if it was becoming too tiring for Mr KS. However we continued and in chapter 6 soon after the Lord's prayer Mr KS responded with a fairly loud "Amen"

A home visit by palliative care team

setting our doubts to rest! We continued listening to the whole sermon and at the end of this the tape flipped over and the beautiful hymn – 'What a Friend we have in Jesus' came on. We left with a word of prayer and tears in our eyes. Mr KS passed away a few days later, peacefully in his home, in the presence of his close family and friends.

We remain grateful that Mr KS had experienced Jesus and that God's Holy Spirit had used the soul-saving words of our Lord to transform our dear friend KS. In ministering to Mr KS with palliative care the Lord enabled his restoration to wholeness and also helped us in our own healing, wholeness and transformation. ■

Dr Stanley C Macaden is National Coordinator of CMAI's Palliative Care Programme and former Director of Bangalore Baptist Hospital.

Dr C K Job
A missionary by calling and visionary by pursuit

Dr M C Mathew

I recall being a student volunteer at a pathology conference in my alma mater, the Government Medical College, Nagpur, in 1972. On the third day (morning) of the conference, the auditorium was overflowing with delegates. When the speaker, Dr C K Job, was introduced as the pathologist who described the aetiology of the Tropical Eosinophilia in 1962 while he was a postgraduate student in Pathology at the Christian Medical College, Vellore, there was thunderous applause. He held the audience spellbound for about 40 minutes with an impressive presentation of this discovery. He had examined hundreds of slides of one lung tissue, when he had gotten tired of reading late in the night. He noticed some granules, which were later identified to be of Microfilaria. The conversation I overheard after the lecture was, 'He is young and will make many more original contributions'. That was a prophetic statement about Dr Job, who later became a pioneering researcher in Hansen's Disease (Leprosy) and published 314 scientific articles, the largest number of publications in research into Hansen's Disease by any one person. He entered his eternal rest on 26 May 2012 at the age of 89 years.

Dr Edward Gault primed him to take up postgraduate training in Pathology, following which he became the Director of Karigiri Leprosy Sanatorium, while retaining his teaching position at the Pathology Department at CMC, Vellore

I had several opportunities to visit him and listen to him. At the last, he talked a lot about the autobiography, *Called to be in His Service,* which he wrote for the benefit of his grandchildren. It was evident from what and how he said, that life was never the same after his wife, Mrs Thanka Job's home call three years back.

Dr Charles Kamalam Job is an outstanding illustration of Robert Lee Frost's famous saying, "Two roads diverged in a wood and I took the one less travelled by and that has made all the difference". Born on 2 November 1923 as the youngest of 11 children, he began the journey of his career as a teacher after graduation, then as an employee in the Travancore government. In 1947, the Christian Medical College, Vellore, decided to welcome men students for the undergraduate medical training. A friend sent him an application form to

Note from the Editor: **The Lives that Speak Beyond Their Times series aims to preserve our collective memory of the people who devoted their lives to setting up / strengthening healthcare facilities in this land of ours many years ago. Lives that inspire us still, they speak beyond their times…**

apply for the admission. That is how his career of the next 65 years began in medicine.

Formative Years

Dr Job had a disturbing experience the day before his interview at Vellore. The men students who came for the interview were made to stay in a hall. Dr Job had securely locked his steel trunk, which had his clothes and certificates. When he woke up in the morning, his trunk was missing. Fortunately, the thief had left the certificates a little distance away. He went for the interview wearing borrowed clothes. Dr Job referred to this as the 'hand of God' in his life.

He was diligent in his studies and became a 'teacher' to his friends. He captained the tennis team of the college. His inherent interest in Histopathology was of tremendous advantage in him becoming a pathologist of repute later. He, who had begun using an electron microscope in the mid 1960s for the first time in India, for his path-breaking research in Hansen's Disease. However, Dr Job described himself as a 'nervous' person, who did poorly in the oral examinations and failed in the University practical examination in Obstetrics because he kept referring to '*posterior*' iliac spine instead of the '*superior*'. It was this experience that made him a humane examiner throughout his career by not failing any student in practical examination, if he or she had passed the theory examination.

He received a scholarship from The Leprosy Mission for his undergraduate studies, which was what initiated him into the world of Hansen's Disease and to work in the Dermatology Department at CMC, Vellore, after his graduation. Soon he had to take charge as the physician in charge of the newly established Schieffelin Leprosy Research Sanatorium (SLRS), at Karigiri, which meant shuttling between Karigiri and Vellore each day, travelling 20 km. It was during this time that Dr Edward Gault, Professor of Pathology, primed him to take up postgraduate training in Pathology, following which he became the Director of Karigiri Leprosy Sanatorium, while retaining his teaching position at the Pathology Department at CMC, Vellore.

Once he heard a visiting professor say, 'If you think of contributing something to the study of medicine, choose the most unpopular subject to specialise in and work as hard as you can'. That is what Dr Job did – he studied pathology and researched Hansen's Disease.

Dr C K Job

It was in acknowledg-ment of his outstanding work that he was awarded the prestigious Damien-Dutton Award in 1993 at the 14th International Leprosy Conference

Family Life

Dr Job had his living accommodation at Karigiri, which became his family home (after marriage) for the next 10 years. One regular visitor to their home during the weekends was Dr and Mrs Gault. Mrs Job referred to these visits as 'manna for the week, amidst the pressures of two jobs my husband was holding'. Mrs Job was a hospitable and prayerful woman, who helped people in need liberally. The regular family prayers at home sheltered them from the woes of several demands and made them seek God in all circumstances.

Their homes at Karigiri and later at Bagayam were a welcome place for pastors, professionals, overseas visitors, colleagues and students. Anand, their son, and his twin sisters, Sudha and Subha recalling what they saw their parents do, mentioned to me once that there was place for others in their parents' life. I remember Mrs Job once showing me her paintings, which she proposed to sell during Christmas time, to raise some Christmas cheer fund for the families in Jawadi Hills. They were the founders of some of the present social involvements of the St John' Fort Church at Vellore.

Research Journey

For Dr Job, research was most natural and simple. The first research question he wanted to answer was the pathogenesis of Hansen's Disease, which he did, through the electron microscopy studies, by showing the transmission of leprosy through skin, and nasal mucosa. The next was transmission of leprosy in wild armadillos by thorn pricks and the pathological changes in organs other than skin. The third enquiry, which was inspired by the research work of Dr Paul Brand, was to find the process of damage to nerves in the disease, which resulted in the loss of sensation and losing of fingers or toes.

The research he initiated at Karigiri and Vellore finally took him to the National Hansen's Disease Centre, Carville, Louisiana, in 1981 for 11 years. It was here that his work with wild, nine-banded armadillos and nude mice revealed substantial and authentic information on the pathogenesis of Hansen' Disease and its mode of transmission. It was Dr Job who established an electron microscope laboratory at Carville. We owe to Dr Job most of what we know about the pathogenesis of Hansen's Disease today. It was in acknowledgement of this outstanding work that he was awarded the prestigious Damien-Dutton Award in 1993 at the 14th

International Leprosy Conference, referring to which the then President of the United States of America, Bill Clinton, wrote to Dr Job, '...your efforts as a scientist, writer, innovator and educator on behalf of victims of Leprosy have been significant in an attempt to provide relief and improve lives…' His international and national awards, citations, conferred leadership positions are too many to recall here.

The Survey, Education, Treatment (SET) model of leprosy control he established in the Gudiyatham taluk and in The Leprosy Mission hospitals later became a model for the National Leprosy Control programme.

His research at Chettupattu, which he took up after he returned from Carville, led to the discovery that in lepromatous patients, M Leprae bacilli were shed from the unbroken skin into the environment in large numbers, which was an eye-opener to the epidemiologists. Dr Mannam Ebenezer, the present Director of SIHRLC, in his foreword in *Called to be in His service* wrote thus: 'Dr Job strode the corridors of CMC, Karigiri, Carville and Chettupattu like a Colossus, an embodiment of excellence and compassion'.

Administrative Leadership

Dr Job became the Director of SLRS, Karigiri, in 1959 from which position he stepped down in 1968. It was during this term of service that the Karigiri campus that had only Palmyra trees began to change with other saplings being planted. The laboratories were upgraded for research, the electron microscope laboratory was established at CMC and training programme for the technicians in research into Hansen's Disease was initiated. From 1962, Dr Job was also the Head of the Department of Pathology at CMC, Vellore, which meant that Dr Job finished all his office work by 7 am at Karigiri with the help of his ever-available secretary, Mr George William, and arrived at CMC to begin the day with the morning prayer and postgraduate seminar for students. During those six years, when he was holding dual administrative responsibilities, he was able to build a team of trusted colleagues in both the institutions.

When Dr Job stepped down to become the Medical Superintendent of CMC hospital in 1975, he left behind a department which had a committed faculty in the sub-specialties of Pathology, Gastro-enterology, Renal Disorders, Central Nervous System, Haematology etc. The way Dr Job kept in touch with his colleagues in his department was by meeting them at their workbench every day around 12 noon. Dr Susie Kurien fondly recalled this at his funeral service.

Dr Job became the Medical Superintendent of CMC, Vellore, in 1975 at a turbulent time when there was a labour unrest. Dr L B M Joseph, referring to Dr Job's role at that time, said, 'even an angry ward boy became quieter before Dr Job, because of his eminent stature.' Dr Job became the Principal of the college, during which time, he demanded more discipline from the medical students in their personal behaviour, for which he suffered hostility from them. Recalling that period, Dr Job wrote in his autobiography, 'I am sure I was in His business. I never lost sleep over the problems I faced'. One legacy, the faculty at CMC, Vellore, fondly remembers is the Ida Scudder School, which was established by him and his colleagues.

Pursuit of a Calling

In the tribute which appeared in the CMC *Newsline* on 4 June 2012 it was written, 'Dr Job was aware of the hand of God leading him throughout his life. While he said he found meaning to his faith in CMC through the example of his teachers and mentors his work and life were Christ-centred. In spite of being feted the world over, he remained a humble person, convinced that he did what God ordained him to do. Leprosy was not his work – it was his calling'. Lynn and Chip Mitchell, whom Dr and Mrs Job met at a church at Carville, invited Dr Job to lead a seeker's Bible study, which Dr Job recalls as a means for his personal growth through the studying of the Bible. Writing about friendships in his autobiography, Dr Job suggests, "It ultimately depends on one's ability to accept another unconditionally; to forgive and forget and also to have humility to be vulnerable." For Dr Job, 'work was a hobby' and he continued working at St Thomas Hospital Leprosy Centre at Chettupattu after returning from Carville at the age of 68 years. From Carville to Chettupattu was an easy transition for him because he was used to yielding to the 'voice of God, leading him'.

One lamentation Dr Job had about Christian hospitals was, "Instead of Christian values permeating the society and its institutions, corrupt values of the world have infiltrated the Christian church and its institutions'. Dr Job carried a dream of revival of Christian hospitals. He summarised his life in his autobiography, 'Goodness and mercy followed us all the days of our lives….I will dwell in the house Lord for ever'. He is now where he was preparing to go. ■

Dr M C Mathew is a Professor of Developmental Neurology, working at the Pondicherry Institute of Medical Sciences.
He is into biographical narratives.

A Century in the Healing Ministry

CSI Kalyani Multispeciality Hospital, Chennai

Dr Rajkumari Sunder

What started as an act of faith by a convert is now the lifeline of the local population as well as of people in a 50-km radius

Introduction

Good health and wellbeing are two essential aspects of human life. Hospitals strive to provide the best of services to the community to maintain healthy living at all times.

CSI Kalyani Multispeciality Hospital is a voluntary health organisation that has been providing service to the community for the last 100 years, striving to eradicate ills through the healing ministry. Located on Dr Radhakrishnan Salai, Mylapore, Chennai, the hospital was born in 1909, thanks to the altruistic and charitable disposition of a Brahmin convert and philanthropist, the late Narayaniyar Subramaniyam, Barrister at Law, who served with distinction as Administrator General and Official Trustee of Madras. He bequeathed the land to the Methodist Missionary Society of London to run a hospital exclusively for women and children in his mother's name – Kalyani.

It was started as a public health centre with 24 beds and later handed over to the Church of South India. CSI Kalyani Hospital has grown steadily into a 220-bedded multispeciality hospital equipped with state of the art facilities in the last decade. Truly following the motto, "God's Vision is our Mission", the hospital has been rendering high quality healthcare services to one and all.

Milestones and Developments

The landmarks in the development of our hospital include the Twin Operation Theatre Complex constructed with the assistance of ICCO, Holland (Interchurch Coordination Committee for Development Projects), which was dedicated by The Most Rev Robert Runcie, Archbishop of Canterbury, on 15 February 1986. This was followed by the major construction of Gerbershagen Ophthalmic Block, which was made possible only through a generous grant by the CBM, West Germany (Christoffel Blindenmission). CBM have so kindly been supporting our eye care service since March 1979. In 1986, the Adiseshiah Special Ward was constructed with eight special rooms, two of which were air-conditioned. The Bethesda OP and Ward located on the ground and Ist floor was constructed in 2002. The Shekinah Ward was constructed as the IInd floor with 12 modern private wards both AC and non AC, as was the Siloam Ward as the IIIrd floor for children with PICU.

Commendable Growth

By the immense grace of God, the institution has grown steadily and now is a full-fledged 220-bedded multispeciality hospital with all major specialities catering to the health needs of all strata of society.

The Primary Aim – Holistic Healing

God says, "Beloved, I wish that you will prosper and be in health as your soul prospers." III Jn: 2

We are extremely grateful to God for enabling us to construct our beautiful Grace Chapel which can accommodate about 400 people. Regular services, praise and worship, fasting prayer et al are being conducted for the staff, students and patients. Healing service is conducted every Sunday evening for patients and their relatives.

"But seek ye first the kingdom of God and His righteousness, and all these things will be added unto you as well." (Mtt. 6:33) The hospital has grown over the last 12

Grace Chapel at CSI Kalyani Hospital

years in its clinical sphere and various departments manned by doctors and technicians have been functioning effectively. See **www.csikalyanihospital.com** for more details.

The plan for the new building at CSI Kalyani Hospital

Training for Academic Growth

To keep abreast of times and the latest developments in the field of medicine, regular courses are conducted for the staff such as:

1. INC, CMAI and government approved 4-year nursing diploma course
2. 2-year diploma course in Medical Laboratory Technology, Medical Radiation Technology (Diagnosis), and diploma in Ophthalmic Technology
3. 1-year Nursing Assistants course sponsored by the Tamilnadu government
4. Postgraduate courses for Doctors – DNB in Family Medicine, General Medicine and Obstetrics and Gynaecology
5. BSc, degree courses in Medical Laboratory Technology, Medical Imaging Technology, Medical Optometry and Ophthalmic Technology

Community Health Work – Outreach Programme

Being a mission hospital, our vision includes taking medical care to the rural poor who stay in satellite villages within a radius of 50 km of the hospital. The rural health centres manned by resident community health nurses have been established in six pivotal villages where the doctors visit the patients every week. During that time, the villages neighbouring to and surrounding the pivotal villages are also visited. In all, the hospital provides medical care for 40 villages covering a population of 35,000 people. Permanent village health guides are also posted to educate the rural mass about health, hygiene and early detection of chronic diseases. Free eye/medical camps are being conducted on third Saturdays of every month.

Extension of Consultant Service

A team of consultants from CSI Kalyani Hospital visits CSI Hospital, Ikkadu, Thiruvallur, Nagari, every week to give consultant services. The Anaesthetist and General Surgeons of our hospital extend their services to CSI Hospital, Ikkadu/Tiruvallur whenever required.

Need of the Hour

As there is a tremendous growth in medical services offered by this institution, and more and more patients are coming in for consultation, surgery and in-patient treatment, there is an acute shortage of beds and private rooms. Due to this, there is also the need for providing modern and high-tech state of the art facilities like the starting of new departments like Cardio-thoracic Surgery, Cath Lab etc.

Hence, it has been resolved to construct a new multi-storey building as centenary project. This building will accommodate more patients and enable this great healing ministry to continue to render the best of healthcare services to the poor and needy at affordable costs and also as charity. May the good Lord continue to make this institution to shine His Light, so that more and more people will see the good works of this institution and glorify our Father in Heaven! Let us arise and build God's kingdom! ■

Dr Rajkumari Sunder is the Medical Director of CSI Kalyani Multispeciality Hospital.

CMAI in the Perspective of WHO Health System Framework

Ms Ashley Thomas

The author, part of the Community Health Department of CMAI, assesses the organisation's work in the light of the WHO Health System Framework

Christian Medical Association of India (CMAI) functions as a network of Christian healthcare institutions and professionals who are committed to serve the Church in India as a national health NGO in its ministry of healing, to build a just and healthy society. Established in 1905 as the Medical Missionary Association, CMAI has since grown and contributed in the areas of mentoring leadership, developing healthcare services, and supporting community health and development initiatives. The World Health Organization states that the health system consists of organisations, people and actions whose primary interest is to promote, restore or maintain health. Hence CMAI's work is reviewed in its totality by using the WHO Health system building blocks and goals (Figure 1). The six building blocks that constitute the WHO health system framework are discussed in view of CMAI's work and mandate.

In the WHO framework, the good **health service delivery** aims to provide effective, safe, quality personal and non-personal health interventions to the needy, when and where needed with minimum wastage of resources. CMAI institutions are known flag-bearers of affordable, relevant and compassionate care for the disadvantaged community which is strengthened through vision-building, organisational development and capacity building in clinical, nursing, diagnostic, management and community services. In 2005, several healthcare institutions in rural India developed as experts in diabetes care under CMAI's coordination. This initiative highlights comprehensive, physical accessible, person-centered continuity of care of CMAI. Meanwhile coordination with local health services, accountability and efficiency of the health care service is emphasised to further strengthen the health service delivery.

CMAI institutions are known flag-bearers of affordable, relevant and compassionate care for the disadvantaged community which is strengthened through vision-building, organisational development and capacity building

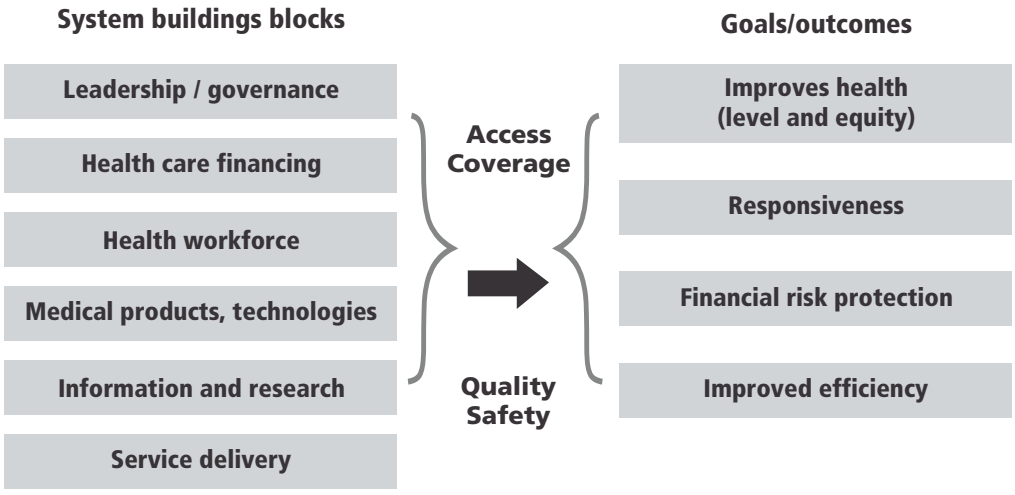

Figure 1: The WHO Health System Framework

As described in the framework, a well-functioning **health information system** ensures the production, analysis, dissemination and use of reliable and timely information on health. CMAI has been active in disseminating information to inform, empower and share experiences and perspectives worldwide through publications and forums, health information

CMAI has fostered and mentored leaders to be technically competent, spiritually guided, and socially relevant to strengthen leadership

system should also guide decision-making and policy development in areas like health research and education, service delivery and financing. CMAI strives to bring together relevant partners to ensure information on health determinants and inequities which are accessible, reliable, usable and understandable.

Equitable access to **essential medical products, vaccines** and **technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use are ensured within a well-functioning health system. In the past, CMAI has advocated on essential medicines and rational use of drugs among the member institutions and has been instrumental in providing essential medical products and vaccines within its coverage areas. The CMAI policy and advocacy team had been pivotal in building perspective among member institutions to promote the rational use of drugs. Similarly, CMAI continues to play an active role to support rational use of medicines, commodities and equipments through guidelines and strategies to assure adherence and maximise patient safety and training among its member institutions.

In accordance with the WHO framework, a well-performing **health workforce** is responsive, fair and efficient in achieving the best health outcomes possible, given available resources and circumstances i.e. there are sufficient numbers and mix of staff, fairly distributed; competent and productive. CMAI strives to achieve this through regular capacity building, formal/informal education and issue-specific training of the healthcare professionals. Limitations in the availability of healthcare professionals and high turnover is a constant challenge among the network institutions and needs to be tackled through innovative methods like m-health (mobile health), knowledge and experience-based incentives.

Within the WHO model, a good **health financing system** is described as one that raises adequate funds for health, in ways that ensure people can use needed services and are protected from financial crisis associated with having to pay for them. Although member institutions within the CMAI network have been pioneers in providing affordable health in rural India, it has not been able to ensure that people are protected from financial catastrophe and impoverishment. Community-based initiatives like micro credit groups and health insurance schemes in the Chota Nagpur region are some of the few small-scale experiences of CMAI. As a national NGO, CMAI aims to emphasise its policy and advocacy in line with health expenditure versus financial catastrophe to improve efficiency and quality of health services provided.

In the WHO framework, **leadership** and **governance** involves ensuring existence of strategic policy frameworks and are combined with effective oversight, coalition-building, the provision of appropriate regulations, attention to system-design, and accountability. CMAI has fostered and mentored leaders to be technically competent, spiritually guided and socially relevant. But certain gaps have been seen in terms of incorporating participation to promote accountability among the stakeholders. Hence, it needs to further enhance its contributions to strategise policy frameworks, effectively oversee and build coalitions to enhance accountability and strengthen the health system design within the CMAI network.

Member institutions within the CMAI network are pioneers in providing affordable health in rural India

The vision and mandate of CMAI aims to improve health, to promote equity, responsiveness and improved efficiency at all levels. This needs to be integrated into the CMAI working model through strategies to build public-private partnerships, mainstream leadership and partner with likeminded institutions for advocacy. The model needs to be strengthened, strategised, documented and disseminated to help define, map and implement plans to address the needs of the country. Hence, the development of a systematic agenda will contribute to meet the complex and changing health care needs.

Ms Ashley Mary Thomas is a Public Health Professional with an Occupational Therapy background who works as the Health Communication Specialist in CHIN Project of CMAI.

A couple had two little boys, ages 8 and 10, who were excessively mischievous. They were always getting into trouble and their parents knew that if any mischief occurred in their town, their sons were probably involved.

They boys' mother heard that a clergyman in town had been successful in disciplining children, so she asked if he would speak with her boys. The clergyman agreed, but asked to see them individually. So the mother sent her 8-year-old first, in the morning, with the older boy to see the clergyman in the afternoon.

The clergyman, a huge man with a booming voice, sat the younger boy down and asked him sternly, "Where is God?"

The boy's mouth dropped open, but he made no response, sitting there with his mouth hanging open, wide-eyed. So the clergyman repeated the question in an even sterner tone, "Where is God!!?" Again the boy made no attempt to answer. So the clergyman raised his voice even more and shook his finger in the boy's face and bellowed, "WHERE IS GOD!?"

The boy screamed and bolted from the room, ran directly home and dove into his closet, slamming the door behind him. When his older brother found him in the closet, he asked, "What happened?"

The youngest brother gasped for breath and replied, "We are in BIG trouble this time dude. God is missing and they think WE did it!"

Source: **www.cleanjoke.com/humor/Where-is-God.html**

Network News

BBH awarded FICCI Healthcare Excellence Award

BBH Director, Dr Alex Thomas, with Union Minister Shri Veerappa Moily

Bangalore Baptist Hospital (BBH) was awarded the prestigious FICCI Healthcare Excellence Award 2012, supported by Quality Council of India for "Successful innovation in operational excellence."

The Federation of Indian Chambers of Commerce and Industry (FICCI), the largest and oldest apex business organisation, is considered the voice of India's business and industry. The award jury comprised of eminent members chaired by Justice R C Lahoti, former Chief Justice of India. The short-listing process was rigorous with spot inspection and presentations to review the application.

BBH was recognised for successful innovation of 'Resident Administrator'; an after-hour management strategy by in-house nursing staff and the unique 'Performance Related Remuneration Scheme'. These innovations have significantly contributed to its operational efficiency. All other chief operational parameters, financial performance, academic research and training, accreditations, environmental conservation and value for money for patients' initiatives were included in the recognition of the award.

This award was received on behalf of Bangalore Baptist Hospital from the President of FICCI, Mr R V Kanoria, on 28 August 2012 in New Delhi. This comes on the heels of the award for the 'The Best Teaching Hospital' by the National Board, Delhi, awarded earlier this year.

BBH is grateful to God for His continued blessings and seek His presence as we serve in the Spirit of Christ.

Transforming into the Imago…

The picture shows Red-base Jezebel (*Delias aglaia*) butterflies emerging from pupae. The picture has been taken by Dr Vijay Anand Ismavel, Medical Superintendent of Makunda Christian Leprosy & General Hospital, Assam.

The butterfly's life cycle consists of four parts: egg, larva, pupa and adult. The egg stage lasts a few weeks in most butterflies. The larva or caterpillar stage involves maturation through a series of stages called instars. At the end of each instar, the larva moults the old cuticle, and the new cuticle expands, before rapidly hardening and developing pigment.

When the larva of the butterfly is fully grown, it stops feeding and begins "wandering" in the quest of a suitable pupation site, often the underside of a leaf. The larva transforms into a pupa (or chrysalis) by anchoring itself to a substrate and moulting for the last time.

The pupal transformation into a butterfly through metamorphosis has held great appeal to mankind. To transform from the miniature wings visible on the outside of the pupa into large structures usable for flight, the pupal wings undergo rapid mitosis and absorb a great deal of nutrients.

The adult stage of the insect is known as the imago. After it emerges from its pupal stage, a butterfly cannot fly until the wings are unfolded. A newly emerged butterfly needs to spend some time inflating its wings with blood and letting them dry, during which time it is extremely vulnerable to predators.

Source: www.en.wikipedia.org/wiki/Butterfly

Picture: Dr Vijay Anand Ismavel

This issue of *CMJI* has been sponsored by Bangalore Baptist Hospital, Bangalore.

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Rational Drugs (RD)
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The current issue gives an insight into 'Use of Non Allopathic Medicines'

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